UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

UNITED STATES OF AMERICA,	)	
Plaintiff,	)	Civil Action
	)	No. 1:07-12065-JLT
vs.	)	September 11, 2009
	)	@10:20 a.m.
WESLEY GRAHAM,	)	Non-Jury Trial
Defendant.	)	Day Three

BEFORE: THE HONORABLE JOSEPH L. TAURO
UNITED STATES DISTRICT JUDGE

APPEARANCES:

United States Attorney's Office
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On Behalf of the Plaintiff.

Federal Defender's Office
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On Behalf of the Defendant.

John Joseph Moakley United States Courthouse
Courtroom No. 21
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Boston, MA 02210

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I N D E X

E X H I B I T S

Marked into Evidence:

P R O C E E D I N G S

THE COURT: We're going right into the jury-waived trial. Where are we, the doctor left?

MR. SINNIS: Yes. The doctor left, your Honor.

MR. GOLD: Yes, she left.

THE COURT: Did she make her plane?

MR. SINNIS: I believe she did. There was a cab downstairs waiting for her so I think that was not a problem.

THE COURT: Okay, good.

MR. GRADY: Your Honor, just one housekeeping matter before we rest. We've got two exhibits that we want to --

THE COURT: I thought you wanted to put her on some more?

MR. GOLD: No.

MR. SINNIS: We may decide to recall her, your Honor, but she needed to go back to Wisconsin to deal with some personal matters ... so if we recall her, it would not be today. We're going to move into -- I don't know if the government's officially going to rest or how the government's handling it?

MR. GRADY: Well --

THE COURT: Well, you wanted some more testimony from her too or no?

MR. GRADY: We're comfortable with where things stand. I mean, if they're willing to conclude their cross

where we were yesterday, we're happy to let things stand as they are.

THE COURT: Well, I have to know that now. You know, that's --

MR. SINNIS: Well, I may have misunderstood your Honor's comments yesterday, so let's clarify that: you gave us an opportunity to recall her if we wanted, correct?

THE COURT: Well, the question is: does the plaintiff rest? The plaintiff is not going to rest until the cross-examination is closed because then the plaintiff can figure out whether they want to have redirect or not.

Now, as I take it, plaintiff's counsel is satisfied to rest if you people rest; and, you know, when I say "rest," we're not going to have any further evidence from this witness who I guess is your only -- the plaintiff's only witness, is that it?

MR. SINNIS: I think my answer to that would be to allow, your Honor, to give us some time to think about that, to call these next two witnesses out of order, to give Mr. Gold and I a chance to talk about that, and then get back to you.

The government has agreed to call these two witnesses out of order anyway.

THE COURT: So it doesn't matter whether you're resting or not?

MR. GRADY: That's fine, your Honor. Could I mention just one housekeeping matter, and, that is, we're going to be putting in Exhibit 31 by stipulation.

I need to get a better copy, but it's going to be introductory sections of the DSM that we discussed on redirect yesterday. It's by agreement of the parties.

THE COURT: Okay.

MR. GOLD: And also, your Honor, we're going to be offering the notes of Dr. Plaud as well who's the next witness here.

MR. GRADY: If they're agreed, they weren't agreed as of --

MR. SINNIS: They can come in?

MR. GRADY: We have no objection, your Honor.

THE COURT: So it's exhibit what?

MR. GRADY: They're marked as Exhibit F in the binder the court already has. We can remark it as Government Exhibit 32, is that correct?

THE CLERK: Correct.

THE COURT: Okay. We're going right along very nicely here, see....

MR. SINNIS: Should I knock on the door?

THE COURT: Knock on the door, see if he's in there ... can you hear him? We're all set for you. Thank you. How are you this morning?

THE WITNESS: I'm fine, sir. How are you?

THE COURT: Good.

MR. SINNIS: Will your Honor give Mr. Gold and I about ten minutes after these two witnesses to make that decision of whether or not we're going to recall Ms. Salter?

THE COURT: Of course.

MR. SINNIS: Okay. Thank you, your Honor. At this time the respondent would call Floyd Young to the stand....

THE COURT: What is this, the 11th?

MR. SINNIS: Yes, your Honor ... you have to be sworn in.

THE COURT: Yes, just a minute. Raise your right hand.

(Floyd Young, Jr., duly sworn.)

THE COURT: Okay. You may be seated.

THE WITNESS: Thank you, sir.

DIRECT EXAMINATION BY MR. SINNIS:

Q. Mr. Young, can you please state your full name, spelling your last name for the record?

A. Floyd Young, Y-o-u-n-g, Jr.

Q. Floyd Young, Jr.?

A. Yes, sir.

Q. And, Mr. Young, do you know Wesley Graham?

A. Yes, sir. He's my uncle.

Q. Okay. How long have you known Mr. Graham?

A. Say ever since I probably was around about three, four.
Q. Okay. When's the last time -- well, strike that. Were you in the courtroom yesterday?
A. Yes, sir.
Q. Is that the first time you'd seen your uncle in some years?
A. Yeah, about five years --
Q. Okay.
A. -- or something.
Q. And why is it that you hadn't seen your uncle in the last five years?
A. Well, the last time I think was when I came up to Jessup; he had moved so far away to here.
Q. When you say the last time you seen him was when he was at Jessup, is that what you said?
A. Yes, sir.
Q. And is that a prison facility?
A. Yes, sir.
Q. Closer to where you live?
A. Yes, sir.
Q. So since he's been moved up to Massachusetts, you haven't had an opportunity to see him?
A. Until yesterday.
Q. Okay. And going back a little bit, you said that you're his nephew, who is your mother?

A. Lizzy Mae Young.
Q. Okay, and was that Mr. Graham's sister?
A. Yes, sir.
Q. Okay, and did Mr. Graham have any other sisters or brothers?
A. No, sir.
Q. And is your mother still alive?
A. No, she just passed June of this year.
Q. And in your knowledge was she close to her brother Wesley?
A. Yes, sir, she was.
Q. And when she was alive and he was down in Jessup, would they visit?
A. Yes, sir.
Q. And would you visit as well?
A. Yes, sir.
Q. How often do you think you visited Mr. Graham during the course of his stay in prisons that were closer to where you live?
A. It was something like a month, maybe two months; maybe a month, something like that, whenever my mom feel like she wanted to go up and see him.
Q. And where do you live now, sir?
A. 65 --
Q. You don't have to give us the full address, just give

us the city and state.
A. I live in Maryland, District Heights, Maryland.
Q. And have you lived there for awhile?
A. Yeah. Approximately about four, five years, something like that.
Q. Where did you grow up?
A. I grew up in DC.
Q. And do you have any siblings?
A. I have kids.
Q. Okay. Do you have any brothers and sisters?
A. Yeah, I have about three brothers and two half brothers and a stepsister.
Q. And you also have children you said?
A. Yes.
Q. How many children do you have?
A. I have three.
Q. And do they live with you?
A. No, Michael does; my other son doesn't and my daughter doesn't.
Q. Okay, and do you live with -- do you have a partner or are you married?
A. I'm married, going through a divorce. I have a fiance and two step kids.
Q. And do they live with you?
A. The two step kids does, yes, and my fiancee does.

Q. And if Mr. Graham is released, would you be willing to have him live with you?
A. Yes, sir, not a doubt.
Q. Do you have room in your house to have Mr. Graham live with you?
A. Yes, I do.
Q. And you would take him in under your roof?
A. Yes, sir, I will.
Q. Do you work?
A. Yes, sir.
Q. What do you do?
A. I do transportation. I transport kids to school.
Q. And do you know anything about Mr. Graham's work history?
A. Well, we worked together a few times. We did some construction work together. He got me that job; and after that ended up -- I ended up working at a car dealership, and I called my uncle up and asked him if he would like to come work up here with me, so I got him a job up here with me.
And he worked in one section, I worked in another section, and we held on, and, unfortunately, he had an issue with a ride so he couldn't get to work and my job was in a different direction so we just couldn't keep up with the time to keep him going.
Q. So you're saying at some point he got terminated from

that job because he couldn't get there?
A. Yes, sir.
Q. And you mentioned that he had gotten you a construction job at one point?
A. Yes, sir.
Q. And you both worked construction together?
A. Yes, sir.
Q. Do you know a woman named Mary, Mary Phargood?
A. Yes, sir.
Q. And did that person have a relationship with your uncle?
A. Yes, sir.
Q. And can you describe for the Court what you know about that relationship?
A. Well, since I was small Ms. Mary had been around us for many years. I never seen no problems with them arguing or nothing like that. We always came over my uncle's, visit my mom. I'd go over to his house, walk through the little park, with her little grandson who used to walk with me and my uncle.
Q. So fair to say that Mary was involved and integrated into your sister's family and Mr. Graham's family?
A. Yeah, we was good friends.
Q. Do you still have contact with Mary?
A. Yeah, she was calling infrequently to talk to my mother, my uncle, and we was talking about her, and you know, just

chatting.

Q. Okay. Do you know whether or not her and Mr. Graham still speak?

A. Well, I know they was -- she was talking to him on the phone on a call. You know, she accepted the phone call and stuff like that.

MR. GRADY: Objection, your Honor. Move to strike for lack of foundation.

THE COURT: I'll sustain it.

Q. Did you ever speak to Miss Phargood or your uncle about whether or not they were still in communication with each other?

A. Yeah, she told me she talked to him on the phone.

MR. GRADY: Objection. Move to strike the portion she told him.

THE COURT: I'll let it stand.

Q. And when's the last time you saw Miss Phargood, "Ms. Mary" as you called her?

A. Mary, I think she had moved because she had a little store down there on Alabama Avenue, and I think her brother took sick or something like that. And she was there for awhile and then she moved, but she stayed in contact with my mother.

Q. Where did your mother grow up?

A. I think in, I think in Hornsborough; I don't know. I

know she moved to DC, and that's where I was raised since I was one years old in Stanton, New Jersey.

Q. Okay. And so your mother had you when -- you were born in DC?

A. Yeah.

Q. So since at least you've been alive your mother's lived in DC?

A. Yes, sir.

Q. And do you know anybody who used to live next-door to where your mother and Mr. Graham grew up, do you know the family that used to live next-door or their children?

A. Well, it was like a few people. I know Darnel, Nell, Cynthia. I think her mother's name was Gray; it was Gray or something like that.

Q. So next-door to where your uncle grew up and your mother grew up there was a family with children named Cynthia, Darnel, and Nell, and you think the mother was Mrs. Gray?

A. Mrs. Gray, yeah. I think her name was Mrs. Gray if I'm not mistaken.

Q. If your uncle should be released at the end of this case, you indicated that he'd be welcome to stay in your home, correct?

A. Yes, sir.

Q. Would you be of assistance to him in trying to help him gain employment?

A. Yes, sir.
Q. Would you help support him in the interim until he could gain employment?
A. Yes, sir.
Q. And he'd be free to stay at your house for any number of months or however long it takes for him to get on his feet?
A. As long as he needs.
THE COURT: What did you say?
THE WITNESS: As long as he needs, sir, as long as he wanted to stay.
THE COURT: As long as he needs?
THE WITNESS: Yes, sir.
Q. You said you hadn't seen him since he left Jessup. Have you talked to him since he left Jessup?
A. Yes, sir.
Q. How often do you talk to your uncle?
A. Whenever he calls.
Q. When do you think that is?
A. Well, he calls -- frankly, you know, talks, says hi to everybody. You know, see how I'm doing and, you know, how is everybody holding up and everything like that.
MR. SINNIS: One moment, your Honor ... nothing further, your Honor.
THE COURT: All right.
MR. GRADY: No questions, your Honor.

THE COURT: Okay. You're excused, sir.

MR. SINNIS: Your Honor, we would call Ivan Young to the stand....

THE COURT: Right up here, sir. Raise your right hand.

(Ivan D. Young duly sworn.)

THE COURT: You may be seated.

DIRECT EXAMINATION BY MR. SINNIS:

Q. Mr. Young, could you please state your full name for the Court and spell your last name?

A. Ivan Young.

Q. Can you speak into the microphone?

A. Sorry. My full name is Ivan Young, Ivan Darien Young, last name is Y-o-u-n-g.

Q. Can you spell your middle name for the court reporter?

A. D-a-r-i-e-n.

Q. And where do you live, sir?

A. I live in Bryans Road, Maryland, in Charles County.

Q. And how long have you lived in Maryland?

A. I've lived in Maryland for about three years, a little over three years.

Q. And do you recognize Mr. Graham?

A. Yes, he's my uncle.

Q. How long have you known your uncle?

A. Now, 42 years.

Q. Is that how old you are?
A. Yes, sir.
Q. Can you briefly for the Court describe your relationship with your uncle as you were growing up?
A. Yes. We -- basically, I mean, when I was growing up, we used to go fishing together. We used to go over his house because he lived at Oxen Hill, and we used to, you know, get together, go fishing. We went and got our license together as well.
Q. I'm just going to take a moment and move this microphone a little closer and ask you to just speak into it, sir.
A. Okay.
Q. You said you went fishing on occasion with your uncle?
A. Yes.
Q. And you said, where did your uncle live at that time?
A. I think it was Oxen Hill right off Lincoln Road.
Q. And do you know who he lived with?
A. Yes, Mary.
Q. And did he live with Mary for some time?
A. Yes.
Q. And did you have occasion to observe him interact with Mary?
A. Yes.
Q. And can you just tell the court what you perceived in terms of what you saw in terms of their relationship?

A. He used to come over the house, visit me and my mother and my grandfather. We used to go outside. We used to play outside and have fun, play volleyball, kickball, and stuff like that. I used to go over his house with him and Mary and sit down at the table, eat, talk, laugh, have fun together, you know.

Q. Did you ever see any violence between the two of them?

A. No. No, it's always been like he's fun. You know, he's always laughing and enjoying himself.

Q. And just so the Court's aware of what time frame we're talking, are we talking roughly in the kind of early to mid '80s, that time frame in there; is that what you're speaking about?

A. Yes.

Q. Do you speak to your uncle now?

A. Yes.

Q. How often do you speak to your uncle?

A. I think it's maybe, maybe three weeks or something like that, almost a month, something like that. Once every three -- or once a month, something like that.

Q. And he calls you obviously, right; you can't call him?

A. Yes.

Q. And what kinds of things do you guys talk about?

A. Well, basically, we talk now. One time he called me asked me -- like I figure if he need something he'd call me

or if he needed to talk, we'd sit down and talk about, you know, how things is going. And he asked how the family's doing and everything. I'd say, you know, everybody's doing fine.

You know, I talked to him about what's going on here about the case here, you know, where the case is at. I was more questioning him, you know, why are things going the way they're going ... because I was kind of puzzled how they're putting him on the new law instead of the old law.

Q. You're talking about you don't quite understand why your uncle hasn't come home yet, is that what you're saying?

A. Yes.

Q. And you say that because you had anticipated, the family had anticipated, him coming home at the end of his prison sentence or why do you say that?

A. Yes, that's why I said that. I figure he should be at home by now. He actually served his time so....

Q. How did your uncle learn that his sister had passed away?

A. I had to call him on the phone, and he ran over to the chaplain, and the chaplain called him in, and the chaplain told him my mother passed away.

Q. And that was in June of this year?

A. Yeah. I think it was June, yes.

Q. Do you have any sense of when the last time was he might

have seen his sister before that?
A. The last time was probably up in Jessup. I'm not sure what year it was, but I think it was like a couple months before he got transferred to Boston.
Q. Did you ever speak to your uncle about the passing of his sister?
A. When she passed I basically talked to him about it and, you know, just telling him, you know, how things was and how peaceful she was and everything.
Q. How did he take it?
A. I mean, death you don't take well no matter who it is: a family member, a friend, you don't take well at all, but a mother, you know, it's kind of hard when you lose your mother --
Q. And how did your uncle --
A. -- and sister.
Q. How did your uncle take it?
A. Well, I was just saying it was kind of hard. He basically lost his father and then he lost his sister, so, you know, it's kind of hard. The only thing he have left is me and my brother, now that my mother's gone. When you lose a family member, it's kind of hard.
Q. So you're the family he has left?
A. Yes.
Q. And as that family he has left, are you willing to help

him if he should be released?

A. Yes.

Q. What types of things would you be willing to do?

A. Anything I possibly can. If he needs, you know, a place to stay or if he needs some money or go out and help him, you know, if it's a job something, you know, whatever he needs me to help him, I will help him.

MR. SINNIS: Thank you very much.

THE COURT: Any cross?

MR. GRADY: No, your Honor. Thank you.

THE COURT: All right, you're excused.

THE WITNESS: Thank you.

MR. GRADY: Can we have that 10 minutes I asked you about now, your Honor; I know it's short, or maybe just 5 minutes to speak to Mr. Gold about the decision with regard to recalling Dr. Salter?

THE COURT: Then what are we going to do?

MR. GOLD: Then we have -- in the event that we say we're not and the government rests, we have a case to put on. We have a witness waiting outside to start the defense -- to continue the defense case.

MR. SINNIS: Dr. Joseph Plaud will be our first witness, your Honor. Our second witness is Dr. Barry Mills who we agreed to start fresh with on Monday, but we have Dr. Plaud ready to go. We just need like two minutes.

THE COURT: Well, you're getting faster and faster. First, it was 10; then, it was 5; now, it's down to 2, and you haven't even started yet, so why don't you try 5 and see. We'll take a five-minute break.

MR. SINNIS: Thank you, your Honor....

(Whereupon, a brief recess convened.)

THE CLERK: All rise for the Honorable Court....

THE COURT: Good morning again, everybody.

MR. GRADY: Good morning, your Honor.

MR. SINNIS: Your Honor, we do not wish to recall Dr. Salter.

THE COURT: Okay.

MR. GRADY: The government rests.

THE COURT: The government rests.

MR. SINNIS: Your Honor, at this time we would actually make a motion, an oral motion, under civil Rule 52C for a finding against the government at this point based upon the insufficiency of the evidence presented.

The government has presented one witness, Dr. Anna Salter, and that doctor has testified that based upon the diagnosis of paraphilia NOS(nonconsent), Mr. Graham, who actually probably should be here but --

THE COURT: Yes.

MR. SINNIS: -- I'll await his presence.

THE COURT: Why don't we do that.

MR. SINNIS: I'm sorry. I just noticed myself.

THE COURT: Please, if it weren't for you, we would have done the morning without him; I forgot all about him. I'm so used to being taken care of....

MR. SINNIS: We all are by Ms. Lovett and all the other clerks....

THE COURT: Go ahead.

MR. SINNIS: Just so the record reflects, Mr. Graham is now present in the courtroom.

THE COURT: Go ahead.

MR. SINNIS: Your Honor, I was saying we would move pursuant to civil rule 52C for a finding that the government has not met their burden by clear and convincing evidence.

The one witness that they've presented, Dr. Anna Salter, has testified that the paraphilia NOS (nonconsent), otherwise known paraphilic rapism, paraphilia, paraphilia coercive disorder, that Mr. Graham suffers from it; and as a cause of that, he's going to be -- it is likely that he would reoffend.

Before I get to that, I just want to say that in terms of antisocial personality disorder, the government is going to respond on cross-examination Dr. Salter said that the antisocial personality disorder does not drive the sexual offending, so I think they're out of the box on that right there. That was a direct quote from what she said during

her testimony.

MR. GRADY: Your Honor, I don't wish to interrupt my brother, but the government would not advance the argument that his antisocial personality alone would be sufficient to support commitment on the facts of this case.

THE COURT: Okay.

MR. SINNIS: So as I hear that, the government is relying pretty much exclusively on paraphilia NOS (nonconsent) or somehow it's a combination with antisocial personality disorder, so is paraphilia NOS (nonconsent) a valid diagnosis, a mental disorder, or illness, or abnormality under the DSM? I think that's the question for your Honor to answer.

THE COURT: Well, I think it is, but why don't we finish the evidence.

MR. SINNIS: Okay. Well, then, I would make that motion on the ground that your Honor is obviously anticipating us to reserve that until the end of the case?

THE COURT: I'll reserve.

MR. SINNIS: Thank you.

THE COURT: Okay.

MR. GOLD: Your Honor, at this time the respondent would call --

THE COURT: I mean, it's essentially the same issue that I had in a different context, the last case I had.

MR. SINNIS: Absolutely, your Honor.

MR. GRADY: Your Honor, if the court is reserving decision, I will reserve argument, but the government would not agree that it's specifically the same issue.

THE COURT: I didn't say specifically.

MR. GRADY: Okay.

THE COURT: It's sort of the kissing cousin, third cousin ... I'm trying to get you to nod.

MR. GRADY: I would not deny either of the Court's observations.

THE COURT: Let the record reflect that it was all done in good humor, everybody smiled.

MR. GOLD: Your Honor, at this time the respondent would call Dr. Joseph Plaud to the stand....

THE COURT: Okay. Doctor, raise your right hand please.

(Joseph J. Plaud, Ph.D., duly sworn.)

THE COURT: You may be seated.

THE WITNESS: Thank you.

DIRECT EXAMINATION BY MR. GOLD:

Q. Good morning, Dr. Plaud.

A. Good morning.

Q. Could you please state your name and spell your last name for the record?

A. Yes, it's Joseph J. Plaud, P-l-a-u-d.

Q. And, Dr. Plaud, what is your profession?
A. I'm a licensed psychologist.
Q. Do you have a specialty in psychology?
A. Yes.
Q. And what is that?
A. The specialty focus of my work as a psychologist from the outset of my clinical training for about the last 22 years has been in evaluating and treating sexual offenders.
Q. Dr. Plaud, I have placed on the ELMO here what has previously been marked and entered into evidence as Exhibit 28. Do you recognize this document?
A. Yes.
Q. What is it?
A. It's a cover page of my curriculum vitae.
Q. And so the record shows it appears to be your complete CV?
A. Yes.
Q. And I've placed what's been previously entered into evidence as Exhibit 27. Do you recognize that document?
A. I do.
Q. And what is it?
A. That is a copy of my psychological psychosexual evaluation report on Mr. Graham dated May 27, 2009.
Q. Now, Dr. Plaud, could you please describe for the Court your educational background starting with your Bachelor's?

A. Yes. I received my bachelor's degree in psychology in 1987 from Clark University in Worcester, Massachusetts, and a Ph.D. in clinical psychology from the University of Maine, yes, the University of Maine in Orono, completing my clinical internship at the University of Mississippi Medical Center in Jackson, Mississippi.

Q. Now, during your Ph.D. studies did you have any particular focus?

A. Yes. Beginning in my first year of graduate school, my focus of training clinically was in evaluating and treating sexual offenders.

My first major professor, whose name was William O'Donahue, that was his area of clinical concentration, and I began working with him in this area at a clinic that he set up at the university providing evaluations of sex offenders, setting up a physiological evaluation lab on campus through a contract with the Maine Department of Probation & Parole.

Q. Could you describe what a physiological lab is?

A. Yes, Dr. O'Donoghue's focus of his research with sex offenders was and continues to be: physiological analysis, assessment of patterns of sexual arousal in males; and I was tasked, since he didn't know too much about computers, computers weren't back in the 1980s what they are now, but, still, we were moving from solid state equipment to

computer-based equipment so my indoctrination into the research lab was to basically to set up the entire lab, to get all the computers working and to come up with the protocols for the PPG, the penile plethysmograph, which is a physiological assessment tool for use with males that measured relative patterns of sexual arousal.

Q. Can you describe for the Court your career steps after your Ph.D. was complete?

A. Yes. After completing my degree, my first professional position, matriculation, was to join the clinical psychology faculty at the University of North Dakota at Grand Forks where we had a Ph.D. program that was accredited by the American Psychological Association in clinical psychology ... so I could sit sort of on the other side of the desk and work with students, graduate students, undergraduate students. We set up our own clinic devoted to evaluating and treating sexual offenders who were referrals from community-based placement services in North Dakota.

As well as conducting research, excuse me, I also did coordinate with local human service agencies on evaluative services they were doing with sex offenders in the area. I was approached by the State of North Dakota to develop their state-wide treatment program for sexual offenders who also have a history of developmental disabilities.

It's a program I did develop and implement at the North

Dakota Developmental Center called the STOP Program, the Specialized Treatment Offenders Program, which continues to this day. I consulted with that program and worked as a consultant, as a clinical faculty member, faculty advisor, for Ph.D.'s dissertations from 1993 until the very end of 1997.

I moved back to Massachusetts in December of 1997 after I would say the great Grand Forks flood made me decide to come back to this area, and I did do so. I received several faculty appointments in this area to teach courses which I did actively for a few years and took a position as the Director of Research for the Cambridge Center for Behavioral Studies and then started my own private practice called: Applied Behavioral Consultants, designed to evaluate and treat sexual offenders, coordinating services with other experts in the area, in the Greater Boston area, and I've continued that work to the present day.

Q. And you're a licensed psychologist?

A. Yes, I'm licensed as a psychologist in the Commonwealth of Massachusetts as well as in the State of New York.

Q. There's a section in your curriculum vitae which details your research grants. Could you please describe your research grant activities as they're relevant to your expertise in this case to the Court?

A. Yes. While on faculty at the University of North

Dakota, I did apply for and receive several grants from the federal government; most of which dealt with my empirical inquiries into the measurement of sexual arousal, the relationship between sexual arousal and sexual behavior. Most of my grant activities were funded through the National Science Foundation.

Q. Now, have you performed research in the area of sex offender research during the course of your career?

A. Yes.

Q. Do you have -- have you published in peer-reviewed journals?

A. Yes.

Q. Approximately how many publications do you have to your credit?

A. In total, I mean, I can count them up on the CV there, but a number of publications. I would say over a hundred publications in toto.

Q. And could you please describe your research interests and publications as they are most relevant to this case?

A. Yes. Well, I've had a number of publications that focus on not only the definition and understanding of what sexual arousal is as a physiological response system in the human male, but the relationship of sexual arousal and disorders of sexual arousal to essentially offending behavior.

I've published in the parameters of understanding how male sexual arousal, the course of it, in other words, the conditioning parameters that underlie the expression of male sexuality through arousal. I've published articles dealing with different strategies used to evaluate sex offenders as well as to treat sex offenders ... so I would say that my research over the years in this area has started with an understanding with and definition of what male sexual arousal is, the relationship between arousal and behavior, and the function of assessment and treatment modalities in addressing deviant sexual arousal.

Q. For the record, I've placed Page 12 of your curriculum vitae on the ELMO. Could you please describe for the Court the publication listed from 1997 with you as the principal author entitled: External Validity of Behavorial and Psychophysiological Sexual Arousal Research?

A. Yes. That article, the research that was the basis for that article, was an investigation as to the applicability of analog research to clinical populations. In other words, most of the research that's conducted, including with issues relating to or having potential application to sex offenders, a lot of the basic behavioral physiological research is conducted with college students, analog samples.

My research was no different, and what I found in the laboratory had -- in writing up, presenting my data, and

discussing the data, and the implications for my findings, where what I found with college students, what applicability does that have to understanding sexual criminal behavior, deviant sexual behavior, deviant sexual arousal, and that article was addressed to the generalizability of college-based analog samples to actual clinical populations.

Q. Now, have you yourself in the laboratory performed experiments regarding arousal with actual human subjects?

A. I have.

Q. And could you describe in some detail how those experiments work?

A. Yes.

Q. Well, I've conducted a number of studies, but I would say most of the studies were designed to evaluate how the introduction of different types of sexual stimuli influence males and their sexual response pattern, the parameters under which males experience sexual arousal, whether or not sexual arousal can be changed experimentally in the laboratory by the introduction of certain types of consequences, whether or not novel or nonsexual stimuli can be conditioned to become sexual in a laboratory setting such that it's a model, it's a behavioral model, that underlie behavioral strategies to change aberrant behavior -- excuse me, to change aberrant sexual arousal ... so what I would do, for example, was to look at the respondent or classbook

conditioning of human sexual arousal.

And in one study I took college students and did some preliminary testing by penile plethysmography, PPG, and determined what their sexual preferences were directly; also of their self-report of their sexual preferences.

I then took relevant stimuli associated with that, compared it with novel stimuli that were not sexual in nature; for example, slides of a penny jar.

THE COURT: Slides of any jar?

THE WITNESS: A penny jar, yes, Judge, a nonsexual stimulus.

THE COURT: All right.

THE WITNESS: And through an experimental condition, I introduced that as a conditioned stimulus, and found -- which resulted in a publication in the Journal of Behavioral Modification 10 or 11 years ago, the respondent conditioning of male sexual arousal; that I could induce sexual response to previously neutral sexual stimuli through specific types of pairing that neutral stimulus with priority-defined sexually exciting stimuli to the person being evaluated. This was all measured by a PPG physiologically in a laboratory.

I also studied habituation, both in the short term and in the long term, as a model for understanding sexual promiscuity and sexual compulsions. In other words, I would

take, again, an understanding for individual subjects what their sexual preferences were. They would be measured on those sexual preferences, and then repeated stimulus presentations of those types of sexual stimuli would occur over different spaced intervals of time, and decrements in response to sexual arousal were measured.

They were reintroduced to see if there was a recovery of the response, and essentially what I found, and some of this research actually did win an award in the Journal of Behavioral Therapy and Experimental Psychiatry in, I believe, 1993 or '94; that I found essentially that I -- I shouldn't say "I," Dr. O'Donahue and I, we worked together on this research ... we found that repeated stimulus presentations, even for highly sexual excited stimuli initially, if they were repeated with a certain type of manner, experimentally we could essentially get them to go down very significantly not only in the short term within the session but over weeks and months so that they would show far less sexual excitement to that stimuli.

And the implication of that was trying to understand how people can stray from committed relationships, for example; this is one implication of it, based on a sexual arousal decrement, so we defined the parameters of both short and long term habituation of sexual arousal in the laboratory.

Q. Dr. Plaud, have you done any research of the kind that

you're describing now, specifically involving sexually coercive stimuli?

A. Yes.

Q. Could you describe that research?

A. Yes, we conducted a number of studies --

THE COURT: Sexually coercive?

MR. GOLD: Sexually coercive stimuli.

MR. GRADY: Your Honor, I'm going to object to this just for the record that Dr. Plaud has no mention in his report relying upon his research in making the diagnosis in this case.

To the extent it is merely for background and to show his experience, certainly it is fair game; but to the extent this is an attempt to lay a foundation for testimony regarding an opinion in this case, based upon his testimony, it was not disclosed in his report, it was not disclosed at the time of deposition; therefore, it would be improper.

MR. GOLD: Your Honor, I'm not sure -- this is part of his expertise that makes him qualified to testify in the case. I don't think I'm heading where the government thinks, but he researches in the area.

THE COURT: Well, go ahead. I mean, we'll take it as part of his background; that's all.

MR. GRADY: And I no objection to that, your Honor.

THE COURT: Go ahead.

Q. Please describe the research that you've conducted which involved sexually coercive stimuli?

A. Yes. I did a number of studies that looked at again analog college samples, first of all, whether or not males could distinguish or differentiate in scenarios where consent to sexual behavior verbally is not given. In other words, for example, the use of the word "no," and the sexual arousal component. In other words, did that verbally-based statement of "no," did that cause people, college students, who were not diagnosed in any way to decrease their levels of sexual arousal compared to conditions when the consent was given ... and I found -- we found essentially no differences between those two issues; that sexual arousal is not influenced or decreased, decremented, by the introduction of a verbal stimuli such as "no" ... implying that consent or stating directly that consent was not given.

This formed the basis for a series of other studies where I tried to yet fine-tune an understanding of whether I could tease out any other factors in students, in the subjects, that could perhaps more reliably focus on whether the coercive -- that certain types of people were more likely to engage in coercive sexual behavior than others, and so I looked at, for example, person's -- each subject's desire for social acceptance or what we call social desirability. I looked at their sexual fantasies, whether

it involved any type of coercive, nonconsensual type of sexual activity; and, again, essentially found that, I mean, there were some differences, but on the whole, it was very difficult to disentangle from the normal population of college students a special subgroup where there was a focus on that coercive -- the coercive nature of sexual interaction with another.

Q. And you mentioned before research talking about the applicability of these types of samples to other situations?

A. Yes.

Q. So does that research have any -- can we draw inferences from it that are more general?

MR. GRADY: Objection, your Honor.

THE COURT: Overruled. I'll let him testify, go ahead.

A. Well, yes, you can, in my judgment, and that's why we did the research: to understand, to try to have an understanding of factors related to when men are told no, for example, by a partner, does that -- that may influence their behavior?

Hopefully, it does influence their behavior on an overt level such that they won't engage in coercive sexual behavior; but, deeper than that: is it influencing their sexual arousal. If a person says no to them, does that port hold water on their arousal level?

We essentially found that it didn't, which is troubling, because if you want to apply it up the scale from analog samples to real-world situations, it might mean that one reason, one explanatory reason why rape or coercive sexual behavior is so prevalent in our society and in other societies is because physiological arousal is still very strong, regardless of the acceptable socially-based feedback, including verbal feedback, withdrawing consent to sexual interaction.

MR. GRADY: Your Honor, the government objects and would move to strike on the ground that counsel is attempting to back-door in information which was not disclosed in the report.

THE COURT: I'm going to overrule the objection. Go ahead.

Q. Thank you. Dr. Plaud, about what time were you conducting this research?

A. I would say '95, '96, '97; those three years was when I was doing most of that research.

Q. Are you currently doing any type of research or do you have any publications that you're working on currently?

A. Yes, I am currently working on several manuscripts; and during the 1990s I was publishing with great ferocity, but that is -- I've slacked off tremendously in the past five years and don't think well of myself, so I've been

endeavoring to get back on track; and the focus of my research now is more on aging and recidivism issues relating to both statistical analysis of risk to reoffend based on our understanding of base rates and other factors that are associated with aging. It comes out of some of the earlier research I had done on chronic medical illness and sexual functioning.

Q. And do you have any research articles that are currently in press or forthcoming?

A. Well, I hope to have soon; I have some on submission right now.

Q. Dr. Plaud, you testify frequently as an expert witness in cases of this kind, right?

A. Yes.

Q. And you testify typically for the defense?

A. Yes.

Q. Now, Dr. Plaud, are you a member of professional associations in your field?

A. Yes.

Q. And what are those or those that are most relevant to the issues here?

A. Well, I mean, I'm a member -- I'm a fellow of the American Psychological Association. That's the association I'm most active in; specifically, Division 41 of the American Psychological Association, which is the American Psychology &

Law Society. I run its lists, serve on the internet; that's the most relevant.

I'm a member of other organizations as well that focus on, for example, behavior therapy, behavior analysis, applied behavior analysis and modification; those are the organizations.

Q. Now, have you ever failed to be qualified as an expert in a case in which you testified?

A. No.

Q. Dr. Plaud, how did you come to be involved in the case of Mr. Young?

A. I think I became involved in this case because I was contacted by you directly and asked if I would be willing to do an evaluation of Mr. Graham, which I agreed to do, and began my investigation and analysis shortly thereafter, I believe, in late April or early May.

Q. And I informed you -- were you appointed by the Court in this case?

A. Well, I'm not quite sure how that works in these federal cases ... I believe I was court-appointed, yes.

Q. Now, did you arrive at an opinion as to whether Mr. Graham meets the criteria for a sexually dangerous person under 18 U.S.C. 4247?

A. Yes.

Q. And what is that opinion?

A. It's my professional opinion that he does not meet the criteria. He's not a sexually dangerous person.

Q. And did you arrive at an opinion as to whether Mr. Graham currently suffers from a serious mental illness, disorder, or abnormality?

A. I did make a conclusion in that area, yes.

Q. And what is that?

A. That he does not suffer from a serious mental illness, abnormality, or disorder.

Q. And did you arrive at an opinion as to whether Mr. Graham will have serious difficulty in refraining from sexual defiant conduct if he is released?

A. Yes.

Q. What is that opinion?

A. I do not believe he will -- well, too, let me just say that as a result of the way it's worded, since I don't believe he has it. I think that's pretty self-explanatory, but I will say that I think he has requisite control over his sexual impulses at this time.

Q. Did you arrive at those conclusions to a reasonable degree of professional certainty?

A. I did.

Q. Can you explain for the Court what you mean when you say that?

THE COURT: Say what?

MR. GOLD: Reasonable degree of professional certainty.

THE COURT: Okay.

A. Yes. Well, when I say that, I mean, based on my training, my experience, my work with sexual offenders over the past 22 plus years, my knowledge of relevant literature, research in the area, and my training as a clinical psychologist, that in my judgment based upon all of those sources that I have an opinion professionally about Mr. Graham at this time that he does not meet the criteria for being sexually dangerous.

Q. Can you describe what you did in your evaluation of Mr. Graham?

A. Yes. The first step was I received records, documents, that pertained to Mr. Graham's background; they were Bates stamped, a number of records, concerning his history of the reports, his criminal history, his sexual offense history, his institutional history.

These were labeled, Bates stamped GR01 to GR939. I reviewed that material. I organized it. I made a number of notes on it. That was the basis then to travel to Devens and conduct a complete clinical interview of Mr. Graham.

I obtained information from the records, supplemented by my clinical interview, and I made, first of all, some diagnostic impressions about Mr. Graham. I looked at some

statistical risk issues and ultimately concluded that he does not have any condition generally acquired at the time of the evaluation that would lead him to have serious difficulty in refraining from sexually violent behavior.

Q. Dr. Plaud, why is a clinical interview important?

A. Well, a clinical interview is important in keeping with ethical principles and best practices because we're evaluating individuals, people, and there are sources of information that we rely on, records we rely on that may be contradictory, especially when you have 939 pieces of paper.

They provide different conclusions, may not provide enough ... so a clinical interview is used most importantly in long diagnostic lines to discuss an individual's background, to discuss their interpretation of certain life events, maybe to put a little more definition in certain areas of the record.

They're not really used for risk assessment per se. It's more in the line of making diagnostic impressions of a person, which not only involves making or clarifying issues in the record, but, also, having direct one-on-one contact with the individual engaging in certain behavioral issues during the interview.

Q. Now, Dr. Plaud, can you summarize for the Court your impression of Mr. Graham's background?

A. Yes, I do summarize this in my report. He was born in

March of 1950 in South Carolina. He had a sister Lizzy, who's ten years older than he was. She passed away recently. She had four sons, so Mr. Graham does have four nephews, which he indicated he has contact with. His parents worked. He was physically disciplined at home; and at the age of approximately 16, he started living with his sister in Washington, D.C. His parents are deceased.

He -- educationally, he went to school to the 7th grade. After which, he left. However, during his term of incarceration he has or made attempts to take some courses to obtain his GED, his general equivalency diploma.

With regard to substance use, he did take alcohol on weekends. He did use marijuana from approximately the age of 14 years to the mid 1980s. He also started to inject heroin at the age of 15 to approximately the age of 21 years.

I did not find any major medical conditions; and according to Mr. Graham at the time of the interview, he did not take any medications.

He worked growing up with his father in roofing. He worked in carpentry. He's had a number of other jobs as a clerk at a number of establishments as well as a security guard.

Q. Dr. Plaud, let me stop you there. What are you looking for when you're collecting this background information as it applied to this assessment?

A. What I'm looking for is to have an understanding of the individual whom I'm evaluating, to have an understanding of disciplinary issues, school issues, behavioral issues, starting when they were young, substance abuse issues, but I make or potentially can make diagnoses of them as an adult.

Some of those diagnoses are based on an understanding of their childhood, their adolescence, they're socioeconomic issues, they're criminal history, et cetera ... so this information informs or assists my judgment in making diagnostic conclusions about adult disorders, personality disorders, sexual disorders, or any other type of mental disorder.

Q. Now, did you consider Mr. Graham's criminal history in your assessment?

A. Yes.

Q. How does the -- well, what is your understanding of Mr. Graham's criminal history?

A. Well, he has a criminal history. It started as a juvenile, to which I also give some specific notation to in my report beginning on Page 4.

When he was 13 years of age, he was arrested, charged with petty larceny; again, arrested at age 15 for simple assault, and several other encounters with the law going up to his adulthood including: substance abuse, motor vehicle and disorderly convictions going up to 1985, separate from

his sexual convictions.

Q. And moving onto his sexual convictions, Dr. Plaud, which are at center stage here, can you describe your understanding of Mr. Graham's sexually -- his sexual convictions?

A. Yes. His sexual offense history includes, going back to when he was in his early '20s; he was 23 years old in 1974.

MR. GRADY: Your Honor, just for the record the witness is reading from his report; I'd just wish the record to reflect that.

THE COURT: Well, I take it, we can do that or have him refresh his recollection.

MR. GRADY: No objection to the testimony, your Honor, just for the purposes of the record.

THE COURT: All right, go ahead.

A. Thank you, Judge ... he had a 25-year-old victim and he sexually assaulted her. Do you want me to go into detail?

Q. Well, why don't we -- if you would, Dr. Plaud, I guess what I'm open to elicit is simply your clinical assessment of the sexual offenses as they relate to the case.

A. Okay.

Q. Well, what happened, Dr. Plaud?

A. On this first instance, again going back to 1974, he's 23 years old. It was a woman he knew, 25 years old. Apparently, he had known her for a number of years.

According to the official version, he picked her up, drove her to a parking lot in Washington, D.C., had told her to remove her clothing. She did not. She refused to do so. He grabbed her, ripped her clothes in her crotch area, removed her pants and panties and then raped her.

He then let her out of the car. He offered to give her a ride to her boyfriend's home. She refused. When she did arrive there later on, she called the police.

She was examined and released at DC General Hospital, and then Mr. Graham was arrested shortly thereafter, charged with rape, for which he received a sentence of 6 to 18 months. That's the official version.

I did elicit from Mr. Graham, his version.

Q. And what is Mr. Graham's version?

A. During the interview Mr. Graham stated to me that he denied raping the victim. He stated that he knew the victim for a number of years when she was -- since she was approximately 13 years old.

He began a sexual relationship with her when they were both teenagers. She had lived next-door. When I asked him therefore why was he accused of raping her? His statement to me essentially was that he was accused because he believes that the victim was upset. He was in a steady relationship with another woman, and she was, the victim, he said was in a series of troubled relationships, had some

drinking intoxication issues, and that he would with great frequency pick the victim up at bars after she became intoxicated and drop her off at her mother's house.

He did not deny having sexual relations with her but stated that it was consensual in the past, but during the time that he was accused of raping her he did not have sexual relations with her.

Q. Now, Dr. Plaud, what did you do with that conflict of versions in your forensic assessment of this case?

A. What I do with that information is what I did with my report. I put the official version; I put what he said, and I proceed along the lines of the official version because of the adjudication.

He was found guilty and had been given a criminal sentence for it. I wasn't there at the time. I don't know what happened. I don't have super powers, so I just take, given the legal consequence; I take the official version as what happened.

Q. So the police report that you read when you did the assessment is the version of the facts that you regard as the facts?

A. Correct.

Q. Is that right?

A. That's correct.

Q. Can you move on to the second sexual offense in

Mr. Graham's record?

A. Yes. In July of 1975, according to the official version, there's an assault of a female in the middle of the afternoon. Mr. Graham was located, arrested, and ultimately charged with assault with intent to rape where he was found guilty in June of 1976.

After his plea he was given a sentence of four-and-a-half to 12 years.

Q. Dr. Plaud, if you could just wait one moment for the court reporter....

A. Again, I asked Mr. Graham during the interview about this assault with intent to which he plead and received a criminal sentence. His statement to me during the interview was that he did not commit this offense. He didn't know who the victim was, didn't know the victim's name, and I asked him then why he pleaded guilty.

He stated he pleaded guilty because he was advised to do so by his attorney. He was told at the time -- he said that the victim was pregnant, and he would probably get a very lengthy sentence if he went to trial and so he pleaded.

Q. So the same question, Dr. Plaud: in this situation of the conflict, what do you consider to be the facts with respect to the second sexual offense?

A. I would give you the same response insofar as that the official version is the official version; that he did plead

guilty to that fact back in 1976.

Q. What you do with the -- in a situation such as this when there is not much factual information about a particular offense?

A. Well, what I do is I take what information I can get from what is available. I don't want to make inferences unnecessarily or incorrectly. I just take the information; and in this case, I have information from the official version that Mr. Graham was charged with assault with intent, and that the victim was an adult female.

I think those are the two most important sources of information, and there isn't a lot of other data in this particular case to make other types of conclusions other than what I just said.

Q. Dr. Plaud, the third sexual offense?

A. The index governing of the instant offense was from 1987. According again to the official version, Mr. Graham forced his way into the residence of an adult female. He had choked her on several occasions to -- basically to unconsciousness, removed her clothing, and raped her.

He was arrested and charged with rape in the first in Maryland, and he was convicted in 1988 on the charge of rape. He received a sentence of 25 years. His parole previously was also revoked I believe for the 1987 charge.

It again involved rape of an adult female. During the

interview Mr. Graham admitted to committing this sexual offense, told me that what happened was at the time he was sitting at a table, a picnic table, in a common area of a condominium development area, and the victim was in that area. She was gardening. They began to talk. They began a conversation. He admitted that he forced himself on her.

He told me that at the time of committing this governing offense he was angry, upset about his parole being violated, returned to drinking alcohol. He was intoxicated at the time of the sexual assault, and that's his version, and the official version.

Q. Now, Dr. Plaud, in the course of reviewing the records pertaining to this offense, did you review the decision of a Maryland Court of Appeals?

A. I did.

Q. And for the record, I've put on the screen Page 513 of the Bates-stamped discovery which is the fact section of the Court of Appeals decision.

Do you recognize that, and is that part of the material which you reviewed in arriving at your conclusions in this case?

A. Yes.

Q. Dr. Plaud, if you don't mind, I will ask you to read the factual section?

A. Yes. "The victim testified that on May 24, 1987, at

8 a.m. she had been working in her garden adjacent to her residence for over an hour when appellant approached her from the sidewalk. Appellant stepped onto the victim's patio and engaged her in a brief 'neighborly-type' conversation. The victim brought the conversation to a close, went inside her residence" --

Q. Just one moment, Dr. Plaud. If I might, does that look like: "Closed the screen door"?

A. Yes, it does. "Closed the screen door, which could not be locked."

Q. "The victim saw"?

A. "The victim saw the appellant had left the patio and had returned to the picnic area nearby. While the victim was listening to the audio of a videotape, appellant again appeared at the screen door and presented her with a plant. She thanked him and again said that she had to go inside.

At approximately 11 a.m. the victim saw the appellant again standing at her screen door with his right hand gloved, and his left hand pressed against the glass. It was then that she became apprehensive.

Despite the victim's protests, appellant pushed his way into her condominium, asserting that he wanted to see the plant he had given to her. When the victim screamed, appellant placed his gloved hand over her throat and dragged her into the living room.

Although, the victim initially struggled to free herself, she stopped when appellant threatened to kill her. Appellant then choked the victim until she passed out telling her: 'I just got to put you out for awhile.'

When the victim regained consciousness and attempted to stand" --

Q. "Appellant"?

A. -- "appellant choked her again. The victim twisted her body so that she could kick the door. She stopped when appellant again threatened to kill her. For the second time the appellant choked the victim into unconsciousness.

Before the appellant initiated sexual intercourse with her, the victim requested that he be gentle because she had not had intercourse for about four months.

After the act was completed, the appellant warned the victim that no one would believe her if she reported" -- I really cannot make it out.

Q. I'm going to -- "if she reported this because there was no sign of forced entry," is that what that looks like?

A. Yes. "The victim requested a glass of tea. Appellant helped her up because she was too weak to stand. At approximately 11:30 a.m. appellant outstretched his hand to guide the victim into her bedroom stating that he 'wanted to make love to her in her bed.'

The second act of intercourse occurred in the bedroom.

Afterward there was some conversation during which appellant requested the victim's telephone number, which she gave to him. The victim thanked him for not killing her."

Q. And if you recall, Dr. Plaud, and we'll stop reading here, how Mr. Graham came to be apprehended in this case?

A. Yes. You don't want me to continue reading or you do?

Q. Sure. Why don't you.

A. Okay. "The victim immediately telephoned a friend. The friend transported her to Andrews Air Force base and later to Prince George's County Hospital where she received -- excuse me, a complete medical examination which revealed trauma to her neck and to her genital area -- genitals, internal bleeding, and the presence of semen.

A Prince George's County Police Officer at the hospital notified Detective Roger Irving who interviewed the victim and began gathering other evidence. Through officer Irving and two other witnesses, there was testimony that the victim had red abrasions on her neck.

During the last of three telephone calls from appellant to the victim at the Pentagon where she worked, Officer Irving and Air Force Agent Andy Martinez were successful in getting a trace on the telephone. It was by appellant. As a result, appellant was taken into custody."

Q. Thank you. Now, Dr. Plaud, does this document form part of what you call the official version when you look for

facts on which to base your conclusions?
A. Yes.
Q. Dr. Plaud, did you diagnose the respondent with any mental condition?
A. No.
Q. How do you go about doing the diagnosis?
A. The manner by which I diagnose mental disorders --
THE COURT: Wait a minute. Maybe I don't understand, are you asking whether he came up with the diagnosis?
MR. GOLD: I did.
THE COURT: And he said no?
MR. GOLD: Yes, and then I'm asking him how does one or how does he go about making or not.
THE COURT: Well, first of all, we don't really care unless he's going to tell us that he came up with one in this case, right?
MR. GOLD: Well, Dr. Plaud details in his report considered certain diagnoses and then did not make them for certain reasons.
THE COURT: Well, that's different.
MR. GOLD: So that's what I was trying to elicit with this.
THE COURT: All right.
MR. GOLD: Question.
Q. Dr. Plaud, did you consider any diagnoses as possible

diagnoses flowing from the facts that we've just laid out?
A. Yes.
Q. And how do you go about or what were those diagnoses?
A. The focus of my clinical examination was in whether or not Mr. Graham suffered from any sexually-based mental disorder.
Q. And what conditions did you determine Mr. Graham -- what conditions did these facts suggest may be present in Mr. Graham?
A. The facts of the sexual offenses that I had just detailed do not, in and of themselves, support any diagnosis for any sexually-based disorder, any paraphilic disorder as contained and defined in the Diagnostic & Statistical Manual of Mental Disorders, 4th edition, Text Revision.

Mr. Graham does not suffer -- does not meet the diagnostic criteria for any sexual disorder in the Diagnostic & Statistical Manual.

Q. Now, Dr. Plaud, is it required of a psychologist to use the Diagnostic & Statistical Manual?
A. That's a very interesting question. Is it required? I would say it is to the extent that that in the western hemisphere is the tone, the classification system, that is utilized in the diagnoses that are generally accepted in the professional community of mental disorders.

There is another diagnostic system called the

International Classification of Diseases, ICD, which does have use in Europe; but in the United States and Canada, the DSM is the major pretty much sole use of the diagnostic system in the definition and diagnoses of mental disorders.

Q. Now, Dr. Plaud, are you familiar with the term: paraphilia.

A. Yes.

Q. And does that term appear in the DSM?

A. It does.

Q. What is paraphilia, Dr. Plaud?

A. A paraphilia essentially refers to intense arousing, exciting, sexually gratifying thoughts, fantasies, or behaviors that focus on sexual interactions/behaviors that go beyond the bounds of normal human experiences that are not within the realm of what are considered and defined as normal or appropriate sexual behavior.

Q. Are there any particular paraphilias that you considered as applicable to this case?

A. Well, the DSM, the Diagnostic & Statistical Manual, discusses by name and by classification a number of paraphilias that range from sexual attraction to prepubescent children, which is a primary paraphilia called pedophilia, to sexual gratification or sexual desires surrounding displaying one genitals in a public venue, to becoming sexually gratified from watching others in a state of

undress, to rubbing up against others, one's genitals against others in public settings.

There are a number of paraphilias that have been defined, and specific types of diagnoses or criteria have been developed in the definition of those paraphilic behaviors.

Q. Are there any particular paraphilias that you considered for this case?

A. Yes. There is one, given the background and the history, the sexual offense history, that I believe did merit the focus of my clinical attention, and that was whether or not Mr. Graham suffered from a sexual sadism, which essentially was the diagnostic label.

Sexual sadism meaning that a person has sexual arousal, excitement, interest, and I did list it in my report as you put up here, for a period of time and has fantasies, interests, behaviors, urges, in which psychological or physical harm, suffering, humiliation is -- the focus is what really drives their sexual interest.

The person has acted on these urges; or if the person has not acted on these urges, the fact that those urges are there are clinically distressing to the person or interfere with that person's occupational or social functioning.

Q. And did you determine that Mr. Graham met the criteria for this paraphilia?

A. He does not meet the criteria. No, he's not a sexual sadist.

Q. And what's the basis, the factual basis, for your conclusion in that regard?

A. Well, again, I detailed his sexual offense history. There are two rapes and an attempted, or an assault with intent, and then I have information about his more general sexual history, and there is no substantiation in that data, including an understanding of his offense history, sexual offense history, that a basis for Mr. Graham's sexual arousal has ever been the focus on the infliction of pain or suffering or humiliation on victim or victims.

There's only one instance where even the specter of that emerges in this particular case, and that has to do with the governing or index offense, and the choking of the victim ... because that type of behavior could be associated more generally with an accurate valid diagnosis of sexual sadism, but I'd have to have a number of things in evidence to substantiate that, not just a description that he has a sexual offense where choking was involved ... because pretty much ever rape contains elements of restraint, coercion, physical assault, as well as sexual assault, to subdue the victim, to make the victim compliant, the use of weapons, et cetera.

Sexual sadists are not using those techniques to get

victims to comply; they're using those techniques to satisfy their sexual urges, such that if they don't have those, they will not be aroused sexually to the victim; and for some sexual sadists, it's not necessarily illegal, some of the activity they do, if they have consenting partners, but that's another issue ...

So I looked at the choking episode and I would say three things about it. No. 1, it's the only instance I have in his entire history including his sexual offense history of the use of that technique ... so it certainly doesn't mean --

THE COURT: The use of what technique?

THE WITNESS: The choking.

THE COURT: Did you have a word before the word "technique"?

THE WITNESS: The use of that technique.

THE COURT: Oh, that technique.

THE WITNESS: In the commission of his sexual offense, the governing offense, in this case. The DSM and the diagnostic criteria sets a period, as it does with all paraphilias, a period of time of at least six months of duration so that's not satisfied on the surface; and that's in there for a very important reason, because there has to be consistency across time for the demonstration of that pattern of arousal or sexual interests to emerge, and that's not met.

No. 2, I don't see any other indication of it, even in the commission of his -- the first rape, or there was no information on the assault with intent that would indicate any pain, suffering, humiliation of the victims.

No. 3, and I think this is important, it relates to what I just read out loud, and that is this: my interpretation, given the way, the words I just read, was that the choking, even though it was a very significant and severe act of violence, was used again to gain compliance by the victim. Even a "I'm going to have to knock you out for awhile," meaning so that I can have sex with you, that's again compliance; and that when she came to, she was trying to -- obviously, to flee from him; and then afterwards, all that stopped and even though he was certainly coercive, he was there, and they had second intercourse, there was none of that involved ... so it does not fit in my experience diagnostically or clinically the sexual sadists that I've treated over the years as even close to a valid diagnosis of what goes into a sexual sadist.

Q. And are you aware of any other expert in this case who's diagnosed sexual sadism?

A. No, I'm not.

Q. Now, Dr. Plaud, did you consider a not otherwise specified paraphilia diagnosis?

A. Yes.

Q. Now, are you aware of the term paraphilia, not otherwise specified (nonconsent)?
A. I'm aware of that term, yes.
Q. Now, is that a valid diagnosis under the DSM in your opinion?
A. No.
Q. Why not?
A. Well, that term, it's not in the DSM. There is no such term as paraphilia not otherwise specified or NOS/ nonconsent.

That term, as I just stated it, does not exist in the DSM. That term was a term that was essentially invented by one person and published in a book that's about seven years ago, and that person's name was Dennis Doren -- is Dennis Doren, D-o-r-e-n. That's his term that he used in advance to be used.

It's not been adopted, accepted by the general professional community; and it's, as I said, not in the DSM, so that term is a term that was published in a book by one individual who has his own theories but that does not represent a valid consensus of professionals in this field who deal with adult rapists.

Q. Well, Dr. Plaud, we heard testimony over the course of the past two days that paraphilia NOS is a commonly diagnosed, the implication was nonconsenting NOS, commonly

diagnosed in sexually dangerous persons cases; is that your understanding?

A. That's my understanding and it's my experience, having worked in this area for the better part of the last decade. Yes, I would agree with that.

Q. And does that indicate general acceptance in the psychological community?

A. No.

Q. Why not?

A. Because every disorder in the DSM, every diagnostic area of classification, including the sexual disorders, contains a catch-all area called NOS, not otherwise specified, which essentially means and really was developed as an investigative, hypothesis-testing diagnosis, a place holder, if you will, such that there may be elements of agreed-upon diagnostic areas, but that the person in question does not satisfy all the diagnostic criteria ... so rather than just jettison it overboard in toto, it's used to basically suggest that there might be something going on with the individual, but that it does not rise to the level of a bona fide diagnosis under the accepted terms that are in the DSM, and so it is a way to communicate that further investigation may be required, but the information we have thus far is insufficient to support any one diagnosis in the DSM.

All diagnoses: anxiety disorders, mood disorders, as well as sexual disorders, have that catch-all phrase; so, as such, if you are licensed, as I am, and have this great power to make diagnoses that supposably carry weight, I could diagnose anyone with a not otherwise specified based on any type of information.

It's the easiest thing in the world to do because there really are no set criteria; that's the whole point. It's not otherwise specified, and it has a great, great, great potential to be misused ... because you can say anything is not otherwise specified, and then when you do that it goes away from its hypothesis-testing or communicative function that more investigation is needed, a function which it may serve a valid point, and for which it is included in the DSM, to this: well, I don't need these diagnostic criteria. He's not a sexual sadist. Okay. I can't say he is, so I'll just say he's NOS, and then I'll just use a term some guy wrote in a book in 2002. That's not right. Unless you -- you have to have substantiation, you have to have data to support that in a paraphilia there is an underlying intense, sexually-arousing orientation in that person that focuses on an area that is definable, that is shown consistency over time, over environment, and drives that -- ultimately can serve as a motivational behavior to drive that person's sexual behavior, whether he acts on it or doesn't act on it

... so I really think it's very, very problematic to use an NOS diagnosis, no matter what other term you want to use with it: nonconsent, interested in tables, you know, whatever you want to put with it ... because anybody can do it; it's the easiest thing in the world, and it abandons the standard of accountability because it's so diffuse.

Q. Is hebephilia often diagnosed in the same way in this type of case?

A. It is, exactly. That's a very good analogy, and I'll tell you why: it's because I investigated this myself in the lab.

MR. GRADY: I'm just going to object to the relevance grounds of this testimony.

THE COURT: Tell me about the hebephilia, what is that?

THE WITNESS: Hebephilia, Judge.

THE COURT: Oh, hebe?

THE WITNESS: H-e-b-e.

THE COURT: B-e, right.

MR. GOLD: No, hebe's the issue we had in the other hearing.

THE COURT: I remember that. Yes, of course.

A. Hebephilia as a term is generated among clinicians and social scientists who are interested in whether or not we can identify specific sexual orientation and interests into

young persons who are post -- or pubescent or post-pubescent.

Essentially, as I said earlier, pedophilia is sexual attraction to prepubescents, children who have not yet evidenced the development in their maturation, their sexual maturation of sexual secondary characteristics ... so, for example, in women: breast development, pubic hair development, hip development.

This pedophile, especially if they're exclusive, once those types of secondary sexual characteristics emerge become less or not sexually interested.

Well, hebephilia was a term of art that was used as a shorthand notation to address: well, is there a classification of individuals who are not pedophiles or not exclusively pedophiles, but yet are not really interested in adults as well?

This middle ground where you have the development of secondary sexual characteristics but they're not 17 or 18; they're not age of legal consent, clearly not defined in any socially relevant or meaningful way as adults ... people, in other words, interested in young boys or girls who are pubescent or post-pubescent, that is hebephilia; and it got even more defined as being generally in the areas of 13, 14, years of age, maybe 15; but then as you get to 15, 16, maybe even 17, there's another term called ephebophilia, e-p-h, so it's the same mechanism but just may be development of more

maturation but still under the age of consent, still clearly not adults in the way that we use it, and this was good in the sense of generating the question: can we identify it? And the bottom line is when it's -- in the DSM it's not diagnosis so for the very same reason or similar reasons why paraphilic types of rape or basophilia, you know, are not in there ... because there's no consensus among the professional community that says this is an identifiable disorder.

In my own work I look at hebephilia and sexual arousal patterns. I recently published on this particular issue in the Archives of Sexual Behavior; in that, it's almost impossible when you have someone who's sexually interested in adults to not find some level of sexual interest in pose-pubescents of that same gender ... so to make it a disorder is to take it to a level that's not supported by behavioral and physiological data.

Well, it's the same thing here with paraphilia NOS/ nonconsent, whatever term you want to use, the data are not there to support that for most men, the vast majority of men who rape women, that the reason they're doing it is based on some disorder, pattern of sexual arousal or interest that is paraphilic in nature ... because their sexual arousal patterns are very similar to normal men, and it has led to the conclusion professionally and a consensus professionally of not adopting it for the DSM.

It's not in there, and, No. 2, and very importantly, to make the indication that most rapists, rape is a crime of violence against women where sex is the weapon in that case ... but it's not the causative, motivational thing that makes them do what they do. There are other issues: anger, negative attitudes towards women, other issues relating to violence, and not a sexual disorder that is inherent in a paraphilia diagnosis, and that's the issue.

Q. Dr. Plaud, we heard very detailed testimony about the criteria in general for diagnosing a paraphilia?

A. Yes.

Q. And for the record I have Page 566 of the DSM, which is the introductory parts of the paraphilia section of the manual, and there is a paragraph entitled: Diagnostic Features. Could you read the first sentence, the Criterion A?

A. Yes. "The essential features of paraphilia are" --

THE COURT: Can you sharpen that a bit?

MR. GOLD: I don't know that. I wish Zita was here.

THE COURT: Well, all right; I can read it. I'll listen while --

A. "The essential features of a paraphilia are recurrent, intense, sexually-arousing fantasies, sexual urges or behaviors generally involving: one, non-human objects; two, the suffering or humiliation of one's self or one's partner;

or, three, children or other nonconsenting persons that occur over a period of at least six months (Criterion A)."

Q. Now, Dr. Plaud, does Criterion A allow a diagnosis of NOS (nonconsent) in your opinion?

A. I would say in -- on the whole, no. Well, no, that's not a valid diagnosis, to use that term, paraphilia NOS (nonconsent), no.

Q. Well, there's a reference here to, I believe, to nonconsenting persons?

A. Yes.

Q. Does that validate a paraphilia NOS (nonconsent) diagnosis?

A. No.

Q. What does nonconsenting persons refer to?

A. Nonconsenting persons refers to children, No. 1, and most importantly; No. 2, it refers to classes of individuals who are associated with mostly noncontact offenders; for example, exhibitionists being the most prominent, victims of frotteurism, those types of disorders.

If you look at the deliberations of the DSM group, the sexual disorders group, when they were discussing nonconsent, it was used mostly in discussion of pedophilia, meaning children are nonconsenting by definition, and exhibitionism.

If you're in a park and a person flashes 70 people in the park, all those people are nonconsenting to being flashed;

they're victims of a, of an exhibitionist; that's the way nonconsenting is being -- is defined in that context.

Q. Dr. Plaud, we referred extensively in testimony over the past two days to two articles, one by Alan Francis --

A. Oh, yes.

Q. -- and other authors called Defining A Mental Disorder When It Really Counts?

A. Yes.

Q. And another by a Michael First and Robert Allen, both of which appear in the Journal of the American Academy of Psychiatry And The Law, No. 36. Are you familiar with this article?

A. I am.

Q. And now Dr. Francis is who?

A. Pretty much all of them are DSM people; these are the people who are associated with the development and adoption of the DSM.

Q. And could you read the first highlighted sentence on the screen, please?

A. Yes. "The term nonconsenting person was meant to apply only to exhibitionism, voyeurism and sadism. It was not meant to signify rapists specifically. Rape was not included as a coded diagnosis, nor as an example of NOS.

While there may be cases where the diagnosis is justified purely on the basis of rape behavior, it was

never intended to convey that these acts alone would be paraphilic.

Some rapes may be triggered by opportunity, others may occur in the context of intoxication related to disinhibition, and some may reflect character disorder or other nonparaphilic pathology."

Q. Dr. Plaud, is Dr. Francis' opinion -- is your opinion consistent with his?

A. Yes. I mean, before this article came out, I mean, I was under the -- I'm very familiar with the use of that term and the deliberations that went into the diagnostic criteria, and that is an accurate reflection, and that's exactly what I just said in my testimony.

Q. Well, Dr. Plaud, are you familiar with the history of paraphilic coercive disorder as it was considered by the DSM --

A. Yes.

Q. -- committees? And what is that history in your understanding briefly?

A. Well, briefly, the history is that it has been --

MR. GRADY: Objection, your Honor; it's beyond the scope of his report and beyond the scope of his direct testimony.

MR. GOLD: Well, it's certainly the subject of testimony in this case. It's a part of his expertise in

which he bases his opinion on this interpretation I believe.

THE COURT: I'm going to let him testify. Go ahead.

A. There are several terms that have been used, paraphilic coercive disorder as a potential diagnosis or paraphilia -- paraphilic rapism, and other terms that are -- the common denominator is that there's an identification in individuals that the basis for their paraphilia concerns subduing victims to having nonconsensual sexual intercourse with victims.

That is the key feature in the consideration over the years under various terms of that type of disorder, and it has been rejected each and every time as being a valid diagnosis because, specifically, there is -- for the 90 -- I mean, almost 100% of those who are adult rapists there's no ability to pick out a difference in their sexual attraction, their sexual arousal pattern, or the demonstration that these specific elements of nonconsent cause them to conduct and commit a sexual offense against adult woman. There's no evidence for it.

THE COURT: Well, what about here where we have the two choking episodes?

THE WITNESS: Yes, Judge, in this case we have the two choking episodes.

MR. GOLD: Your Honor is referring to the two chokings and the one episode?

THE COURT: Yeah. Well the two separate chokings

anyway. If you want to call it one episode, you know what I'm talking about?

THE WITNESS: Yes.

THE COURT: The occasion where he choked this lady twice?

THE WITNESS: Yes.

THE COURT: While he was there?

THE WITNESS: Yes, Judge, and here's my response to that, because I did consider that.

I've worked with a number of rapists, you know, over the last two decades. In men who rape woman the most common denominator is that there are elements of violence, severe violence, including: choking, attempted strangulation, binding, threats of force, use of weapons, et cetera. The question is why, why are they doing that? The bottom line is why? What's the answer to the question?

And for these men the answer to the why is to get the victim to comply with them, to subdue the victim in order to engage in sexual intercourse with the victim ultimately; that's why, to restrain the victim, to make the victim more pliable. That's why they threaten them. That's why they tie them up. That's why they choke them. That's why.

THE COURT: So the choking is not the end; it's the means to an end?

THE WITNESS: Exactly. It is the -- very good, it's

the means to the end. It's the mechanism in this case whereby he gained sexual access to the victim, and what I was reading earlier from the record, he subdued the victim. He threatened the victim. She was trying to escape. He choked her. He even said it was a quote, I'm going to put you out for awhile, to have sex with her.

She regains consciousness, tries to get away, and only then did he try to choke her again, again, to get compliance; that's the "why," the means to an end, exactly.

Now, in a smaller group of rapists who are sexual sadists there is, and you will see time and time again that they do engage in a variety of violent, assaultive, demeaning humiliation-based strategies, even verbal humiliation, never mind physical violence, with victims as a prerequisite to getting sexually excited, and then engaging in sexual behavior with the person, but that is a different animal altogether from what I see in this case.

Q. Dr. Plaud, assuming for the moment that there was evidence as you said suggestive of a paraphilia diagnosis --

A. Yes.

Q. -- would that be sufficient in your opinion to justify a diagnosis based on the totality of the circumstances?

A. No.

Q. Why not?

A. Because as I said earlier, in the diagnosis of

paraphilia is the requirement, standard requirement, of evidence of this type of sexually-arousing thought, fantasy, behavior for at least six months duration; it's at least six months duration, and this is the only -- this happened one time. One victim, one time; that's all I know.

In his sexual history with others, with his long-term girlfriend, there's no evidence that he engaged in this behavior; there's no evidence anywhere of that six-month period being satisfied.

Q. Well, but, Dr. Plaud, you do have the two prior sexual offenses, don't you?

A. Yes.

Q. And don't those support an inference that there's a pattern of behavior?

A. It's certainly not an inference. There was a pattern of behavior with three episodes: two rapes and one assault with intent, where he engaged in violent and illegal behavior, sexually coercive in nature, with an adult female, but the issue has to do with not illegal behavior on the surface of it, but what was motivating him to engage in that behavior.

And is there any evidence that it was motivated speaks to the heart and sole of the significant criteria definition of mental abnormalities, et cetera, is: was it motivated by a paraphilic sexual interest that at this time would make

him have serious difficulty controlling his sexual conduct if he were released from a secure facility, and that's the issue; that the vast, vast majority of rapists do not rape women because of an underlying sexual deviance. That's not what's motivating, empowering the illegal and violent behavior. It's something else, or a combination of factors so you can't just use the rape itself as the explanation.

Q. Dr. Plaud, is it ever permissible to diagnose sexual arousal to rape under an NOS classification?

A. I believe it is possible, yes.

Q. What is the difference between that position and your criticism of the not otherwise specified nonconsent diagnosis?

A. There's a very straight-forward answer to that. There has to be evidence that the person is sexually excited by the act in and of itself by engaging in nonconsensual sexual behavior. What level of violence or not is secondary.

The bottom line is you have to have objective data over a period of time that the person is acting on an underlying sexual arousal pattern, interest pattern, to the act itself of engaging in nonconsensual behavior with others. That has to be in evidence. That has to be clear.

And over the years and over the many, many hundreds and hundreds of sex offenders, rapists, that I have dealt with, evaluated, treated, I can tell you that it's almost -- I can

-- I think I've used the term on one hand, and that's even being -- giving it a very easy definition. I could count the number of people who are rapists who probably could have begun to be considered in that category, so it's a very small minority of rapists, and there has to be exceptional data which I generally do not find either in records or any other sources of information that men are most -- the vast majority of men are raping women for reasons that have nothing to do with their sexual arousal.

They're doing it for reasons of anger or violence. As I said, rape is an act of violence where sex is used as an expression of that violence ... like when other people are acting on violence, they use weapons on other people and no sexual behavior or whatever. It's not the motivator; it's the tool that they express something else going on.

Q. Well, Dr. Plaud, is it ever in your view appropriate to offer an NOS diagnosis in a forensic environment like this?

A. I would myself be hard-pressed to do that because I think, you know, to put it simply, as Cole Porter wrote many years ago: anything goes.

You can justify or say anything. You can put anything in an NOS classification. It's a self-threshold diagnosis; it's not otherwise specified. It's exploratory. It's hypothesis-testing.

It isn't some magic diagnosis that sets the stage for an

understanding of that person whether it's their sexual interest pattern or any other type of NOS diagnosis among other disorders. It's just not sufficient as a diagnostic category in my judgment for implications that -- and the definitions we have like in recivil commitment laws.

Q. And is there a difference in your opinion from making a diagnosis in a forensic situation to making a diagnosis in a clinical situation?

A. Absolutely.

Q. And what is the difference?

A. Well, in a clinical situation if I'm making an NOS diagnosis, what I'm communicating either to myself, if I'm the treating clinician or doing further evaluations, or to other professionals who may be reading what I'm -- my report or my recommendation might be exactly what I said earlier, that I think there may be something going on here; I don't have enough data. The person does not meet established standard criteria as defined in any of the diagnostic categories in the sexual disorders under the DSM, but I think we need to have some more investigation. I think we need to do a little more finding out of information if possible, but there's just not enough to go on.

Q. Dr. Plaud, are you familiar with who Dr. Fred Berlin is?

A. Yes, I know Fred.

Q. And could you briefly describe who he is in the field

of sex offender research?

A. Yes. Fred Berlin is at Johns Hopkins University in Baltimore. He's a very well-renowned expert in the field of sexual disorders work, working with sex offenders; he's a psychiatrist.

Q. Now, we heard testimony yesterday that Fred Berlin has testified that he supports making a paraphilic rapism or coercive disorder under the NOS category.

The first question I have for you is, is it customary -- did you read Dr. Salter's report?

A. I did.

Q. Is it customary when discussing a diagnosis that you're putting forward to cite to other professionals' work or testimony?

A. No.

Q. Now, we heard testimony that Dr. Berlin supports doing that, in that Dr. Berlin is on the DSM --

THE COURT: Doing that meaning what?

MR. GOLD: Oh, diagnosing a rape-related disorder under the NOS category....

Q. Now, in that Dr. Berlin was associated with the development of the DSM-IV, why doesn't that mean you can do it?

A. Well, because -- very simply, because what's in the DSM is what's in the DSM. It's a public version and it's the

product of deliberations in a group of professionals and decisions made by a group of professionals.

Now, in that group or in the advisors to that group, if they're not central, there may be some differences of opinion professionally; but at the end of the day, it's what's in there that counts, not what the myriad of individual opinions might be in terms of making diagnoses ... so I'm certainly not fully aware of what you just said about Dr. Berlin's testimony to that effect, so I can't comment directly on it, but I can say that even if it's -- even if he did make some comment like that, that carries no weight because the DSM is what it is. It's a public version and what's in the diagnostic criteria are the latest understanding of accepted diagnostic categories by the group that compose the sexual disorders task force.

Q. Are you familiar with the criteria that Dr. Doren proposed for his not otherwise specified diagnosis?

A. Yes. I mean, I've read it many times. I don't have it right here in front of me, but, yes.

Q. Well, what is your -- doesn't Dr. Doren resolve the problem of the lack of criteria in the manual?

A. Well, he may think he does by saying or putting forth criteria he thinks may be worthwhile or valid or that may distinguish rapists as a specific class of paraphilia; but if he thinks this is the case, then he needs to propose

criteria to the diagnostic working group and see what happens.

That's, that's where the rubber meets the road. I mean, I can sit here, give me five minutes, I'll come up with 16 other diagnoses. I could sound very philosophic about, use very technical terms, but who cares? It's whether I'm doing it seriously or whether I'm just doing it as a thought exercise; it's my opinion.

It's my opinion and my opinion in this sense is overweighed by the DSM; that is the agreed-upon diagnostic classification.

I have some issues with the DSM. I haven't met a clinician who doesn't, but I'm not here to say: well, you know, I don't think pedophilia should be in here. I don't think exhibitionism should be in there. You know, these are agreed-upon diagnostic categories, and they're there for a reason.

Q. Well, now, we heard testimony yesterday that the NOS category lists examples?

A. Yes.

Q. And it says that those examples, it's not an exhaustive list?

A. Correct.

Q. Doesn't that allow for what was done in this case?

A. No.

Q. Why not?

A. Because here's the key to that question, there are any number of labels you could come up with that define what the object or area of sexual interest might be ... and an NOS diagnosis, because you can't capture everything in the classifications that are in the DSM under the sexual disorders ... so, for example, there's a nice sounding term telephone scatologia.

Probably you heard about it as obscene telephone calls or crank calls growing up ... now, that in and of itself, there's no separate diagnostic criteria for that. It's just a paraphilia when the diagnostic criteria for paraphilias are satisfied, but relates to demonstrable evidence that the person gains sexual interest, excitement from making sexually suggestive telephone calls.

That would be a paraphilia not otherwise specified, but the diagnostic criteria for paraphilia in general are specified and are there; it's just that the term otherwise isn't in the DSM under its own separate heading.

You could go on for, you know, 200 pages. The same thing with zoophilia or what's known as bestiality, which is also an example or specific -- you know, coprophilia or urophilia, different types of sexual attraction to different, I should say, less tasteful aspects perhaps of sexual encounters with other people.

That's a totally different way to understand it, but the bottom line is: in all of those cases you have a demonstration that the person has specific sexual arousal, interest, urges over a period of at least six months to engaging in this behavior or acting on those urges.

There's no evidence that nonconsent per se is an initiator of a paraphilic sexual type of behavior; that's the difference. That is the difference.

Q. Could you explain to us, Dr. Plaud, how these five clinical cases that you saw in the past where you would consider a paraphilia NOS diagnosis, first, were those in clinical or forensic context?

A. Clinical.

Q. And why is that important, if it is?

A. Well, the diagnosis was used insofar as, again, communicating information about their sexual interest patterns in the context of treatment rather than any type of legal designation they may fall in as a result of it, and I would add in all of those cases I would suspect sexual sadism but didn't have enough information.

Q. Now, we heard extensive testimony about laboratory research, citing numbers of peer-reviewed articles about differences between rapists and nonrapists in the lab?

A. Yes.

Q. Are you familiar with that research?

MR. GRADY: Your Honor, I'm going to object. Again, there's been no notice that this witness was going to provide expert testimony on this subject in either his report or his deposition.

Indeed, this expert's report was prepared after Dr. Salter's; and if they wished this expert to address Dr. Salter's opinions, I would believe it would be incumbent upon them under Rule 26 to disclose the nature of those opinions, the basis upon which he is opining on Dr. Salter's opinions, or the validity thereof, and that that should be disclosed in a report prior to trial.

MR. GOLD: With respect to the timeliness, Judge, we got the bibliography that the government cited very recently, but I think the bigger point is that this is the body of research that any expert who's competent to testify in this field should have in their mind to be qualified to testify about as it informs their opinion.

I think to the extent that it's not anything that Dr. Plaud will say about the testimony, it should be part of the common fund of knowledge that lies behind what he's saying and is implicit in the reports that we have, and is part -- in fact, Dr. Plaud conducts part of this research; this is part of why he was called as a witness in this case because he's knowledgeable about it.

THE COURT: I'm going to let him testify. Go ahead.

Q. What is your understanding with regard to the research regarding laboratory findings of rapists compared to nonrapists?

A. Well, I will tell you that the most important statement I can make is: overall, if you look at the data in the laboratory over the last several decades in the aggregate, it's very difficult, if not impossible, to differentiate rapists along the lines of deviant sexual arousal.

In other words, it's hard to pick them out based upon physiological data on deviant arousal to sexual violence for two reasons: No. 1, they don't show differences within the clinical sample itself ... so if you just segregate rapists, you'll see that there's a lot of homogeneity in their arousal pattern; but, more importantly, if you compare that group to normals analoged, you don't see differences. That's why that's -- that's the most important reason why it's been rejected diagnostically over the decades is because it's so difficult, if not impossible, to differentiate the two; that most rapists are not acting on deviant sexual arousal, that's why the diagnosis per se isn't in there. That's why paraphilic rape has been jettisoned.

Now, let me also say, and some of my research is in this second area, is: if you take a group of rapists and you try to tease out some differences, whether among psychological dimensions or even physiological dimensions, on arousal, and

try to fit those in with typologies, for example, that have been developed to classify different types of offenders ... there are some studies that have indicated that there might be a way to parse out some rapists and put them in a more sexualized versus less sexualized group.

It's not so much about the deviant arousal as is the level of sexual arousal that they have, rather than being qualitatively different on the deviant side; but a lot of that is based on very small numbers, there's not a lot of it to support it in general; it's more exploratory.

I would say even three or four decades later when some of this first research comes out, it's still all very exploratory. Most of it that even does point to any differences are based on very small numbers, and large numbers of rapists are always excluded from the studies, which is mind-boggling ... because what does that do? There could be -- if you're excluding a bunch of rapists from the study, what validity, what external generalized ability does your study have?

That's one reason I chose to analog subjects in toto to do this research, so I could look at a more normative group and see if there was something going on there I could understand ... so that's the character of the research; there's really nobody's research, I'm here to tell you, that demonstrates this qualitative difference either within

rapists or between rapists and nonrapists sexually, sexual deviance, paraphilia wise; it's just not there with any degree of precision.

Q. Assuming -- moving on to a related topic, Dr. Plaud, assuming for the moment that you did have a valid paraphilia diagnosis in the past, is it of any relevance at all that it would be in this case 22 years old?

THE COURT: Say that again? I don't quite understand.

Q. Assuming for the sake of argument that you had a valid paraphilia diagnosis of some kind, does the age of the diagnosis have any relevance at all?

THE COURT: In other words, adding nothing to the facts, just --

MR. GOLD: Adding nothing to the facts?

THE COURT: Does it have a shelf life?

Q. Just the passage of time, does it have a shelf life?

A. The short answer would be: yes, it does have a short shelf life, and the further back the data go, the more dubious the diagnosis.

Now, there are paraphilias and the DSM speaks -- uses the term oftentimes considered to be chronic, which means they have power over time. They last, but it depends which paraphilia you're talking about.

Some seem to have more power over time than others; for

example, pedophilia, especially what the term is, fixated pedophilia, meaning exclusively pedophilia in diagnostic terms, does tend to have more consistency over time.

However, there are even a number of caveats to that, and let me put that aside, just to use it as an illustration.

For rapists, no, there's no evidence that a paraphilia diagnosis in and of itself over decades just propels itself that the motivational basis stays in tact, or that it will impact a person later in life as it may have -- I mean, I'm speaking to your hypothetical question, so if it was there in some degree earlier that it would last.

People, and I get this information, for example, for exhibitionism as a paraphilia; exhibitionism can be very changeable over time and have change as a function of absolutely no intervention at all ... because in exhibitionism, to a large extent, many exhibitionists are not deviant in the sense that they're trying to flash children; some are, but they act on anxiety or depression, which, if remediated, in and of itself, makes the exhibitionistic behavior go away as well ... so in a case of any kind of NOS paraphilia, there's no assumption that it will last over the decades, none. It needs to have some more recent data to back it up.

Q. And continuing with the hypothetical but going on the facts in this case, are there any facts since his conviction

which would be consistent with a paraphilia diagnosis?
A. None.
Q. Now, there's no disciplinary record?
A. No.
Q. Are you aware of any record of sexual misconduct?
A. No, meaning, in an institutionalized setting since the governing offense?
Q. Yes.
A. No.
Q. Are you aware of any disciplinary reports in the records for Mr. Graham for the past 22 years?
A. I am not aware of any as I sit here, no.
Q. And assuming the validity of the diagnosis, would that be a factor that you would consider?
A. Yes, of course.
Q. Why?
A. Because the decision in these cases is it's a decision about Mr. Graham today. Now, that decision is informed obviously by Mr. Graham yesterday and the day before yesterday and ten years ago and 20 years ago and 30 years ago, but the farther out you go in time, the more tenuous his current status, especially if we're talking about disorders, mental status, the more tenuous it's going to be.
You need to have some data, and, preferably, more recent in time, to substantiate ongoing difficulties ... because any

diagnosis in the DSM, as is stated repeatedly in the book, does not carry with it any implication about a person's current capacity to control that behavior, to act on that behavior, or to be influenced by whatever it is that is underlying historically that behavior, and that's where you need to have more current data ... so if a person is continuing to act out sexually, making threats against staff, sexual threats, engaging in rape behaviors in prison, et cetera ... well, that would certainly be a strong indication of something continuing to go on that would be problematic and support perhaps an earlier diagnosis or diagnoses based on behavior 22 and more years ago.

The absence of that however is the absence of it, so it makes whatever you wanted to decide 22 or more years ago more tenuous on the surface.

Q. Now, just to clarify, the DSM speaks to the issue of whether a diagnosis in itself indicates that there's volitional impairment?

A. It does not. It does speak to the issue in the sense that it says that it does not carry with it any statement about a person's current volitional capacity to control themselves.

Q. So as you as the forensic psychologist doing this work, if you found a valid paraphilic diagnosis, would you attempt to make an additional finding as to volitional impairment or

what would you do?

A. Well, I think that in this context I think it's a critical issue; it's a central issue. I mean on Page 10 of my report I provide a quotation from the DSM that speaks to the issue of volitional cast capacity to control and what the DSM itself says about it in the sense that on Page 23 of the Roman Numeral section in the preface, "in the DSM-IV, it is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability."

So that is always an issue that should be considered: a diagnosis alone is not sufficient; it's a necessary but not sufficient statement, so it's really an analysis, so if you're labeling someone with a paraphilia, that's step one; in this case, I'm not, so I don't need to go to step two, but if I did go to step one, and I diagnosed Mr. Graham with a paraphilia not otherwise specified, I wouldn't put nonconsent in there.

I'd just put paraphilia not otherwise specified, and then I'd give a verbal description. I would then as a clinician tasked with the responsibility professionally of relating to the best of my ability, making conclusions about his current level of volitional control over that area of diagnosis.

Q. Did you consider a diagnosis of antisocial personality disorder in this case?
A. I did.
Q. What conclusion did you arrive at with respect to that decision?
A. My conclusion specifically was that -- I mean: look, it's not out of the realm of possibility that Mr. Graham, given his criminal history beginning as a juvenile, the diagnosis by record could be made; but, if you factor out his sexual offense history as an adult, his criminal history, as well as his institutional history, lack of disciplinary reports, demonstration over decades of an ongoing ability to comport behavior to social norms, rules, regulations within the institution, coupled with the fact that he's 59 years old and burnout is a big factor in the diagnosis of ASP.
Q. Let me stop you there, Dr. Plaud.
A. Yeah.
Q. Could you talk about, does the DSM say anything about this concept of burnout?
A. Yes.
Q. What does it say?
A. That aging does impact the diagnosis or chronicity or the applicability of the diagnosis of ASP, antisocial personality disorder, beginning in the third decade of life; of which Mr. Graham is now well over ... so it's not

impossible to make the diagnosis, certainly, but, again, I look at it more functionally: Does he now, as a 59 year old man, with evidence of his behavior in the last, you know, two decades, is there an indication that he meets the diagnostic criteria as specified? Not really, No. 1.

No. 2, in and of itself even if you had the diagnosis, so what? Who cares? That is not enough to make any statements regarding propensity to engage in sexually violent behavior. It's not in and of itself enough ... so even if you want to grant that he has it, in and of itself, it's a footnote.

Q. Now, Dr. Plaud, you arrived at the opinion that -- well, let me ask you, what is your opinion with respect to the third prong of the statute, serious difficulty refraining from sexually violent crime?

A. Well, I really think again it's important to point out that its prefaced, the third prong, as a result of, words to that effect, if I may refresh my memory; but as a result of his serious mental illness abnormality or disorder, that is, that's the first part of the third tier.

If he doesn't have that disorder, then by definition you don't have to waste too much brain activity going further. The answer would be no because he does not suffer from the condition; but if I wanted to take a diagnostically neutral stance and just look at this empirically, statistically

risk-wise, I would still say no.

Q. And why is that?

A. Because Mr. Graham apart from --

MR. GRADY: Your Honor, I'm just going to object for purposes of relevance. If the witness himself has acknowledged my testimony is this is not going to answer the question presented by the statute, it doesn't seem to be informing the Court's opinion.

THE COURT: I'll let him have it. Go ahead.

A. As I said a moment ago, Mr. Graham is now 59 years old. He is now millimeters away from an age cohort which is associated with extremely low rates of sexual recidivism, Reoffending in a sexual manner ... so if you want to just look at this from a statistical perspective, taking out the issues of mental disorders, serious mental illnesses, disease, whatever term you want to use, and just look at this from what we know about men with criminal sexual histories who are rapists, and their recidivism rates at his current age what you find is he's in a statistically or will be or he already is but very shortly will be even more in a grouping of men who are in the lowest possible group to reoffend ... especially absent any underlying condition that would motivate him potentially to reoffend such as a true paraphilia.

Q. Now, Dr. Plaud, I want to back up a little bit and ask

you: when you are presented with the referral question as a result of a mental illness, abnormality, or disorder, serious difficulty refraining from sexually violent conduct, what is the statute in your mind asking you to do?

A. In my mind what the statute is asking me to do, No. 1, is: given adequate sources of information, records, and any other source of information that's sufficient to make professional conclusions, the first step importantly is to be able to make a diagnosis, to provide a step, an understanding, defining specifically that the person suffers from a disorder pattern of sexual interest, a paraphilic sexual interest, and/or a personality disorder.

And then if the answer to that is yes, that you can diagnose them credibly, validly, with a paraphilic disorder or a personality disorder, then, to go to the next stage to say: well, does the presence of this condition make it likely that they would reoffend, cause them serious difficulty controlling their behavior if they were not confined; that that motivational basis underlies their behavior such that if they didn't have the constraints of an institutional setting they would be at risk to reoffend.

Q. Now, how do you -- do you use a particular method in going about answering the risk to reoffend question?

A. The best answer I can give is: it's more of an open-ended issue at the present time. I'm having very

significant difficulty -- I can't answer that yes or no.

Q. Well, Dr. Plaud, give us and the court, if you will, a bit of background to explain your present difficulty?

A. Okay.

Q. Are there different methodologies to conduct a risk assessment?

A. Yes.

Q. And what are those?

A. Well, there are certain terms of art that are used generally to describe different methodologies ranging from a clinical type of methodology, which essentially refers to the clinician in question basing professional judgments about risk to reoffend on their training and experience working in a particular area or a particular group of individuals.

On the other end is a statistical or actuarial methodology, which refers to the computation of one or more actuarial tools that have preselected items that on the surface can be measured, can be scored, can be weighted, and then the scores can be compared to preselected groups reference groups who score the same or similar to that person and were followed over a period of time and their reoffense rates over 5, 10, 15, 20, years, noted.

And in between there's techniques that have been referred to, for example, as adjusted actuarial, starting with actuarial as a risk assessment, and then adjusting that

based on other factors that are not in the actuarial tool or empirically, structured clinical approach, which involves at least the clinician in question saying they're basing their judgment on the relevant scientific literature, whatever that literature might be.

Q. Now, Dr. Plaud, is there a -- were there concerns about clinical judgment? Would you like a minute, Dr. Plaud?

A. Oh, no, I'm fine. Thank you.

Q. Were there concerns about clinical judgment that led to the development of these actuarial instruments?

A. Yes.

Q. Could you briefly describe that history to the Court?

A. Yes. Clinical judgments of risk to reoffend, I'm talking -- I want to be specific to sexual offenders to making risk predictors of future probabilities to reoffend in a sexual manner ... when those decisions are left to clinicians, even ones who at least on the surface had proper training, who worked with relevant clinical populations over time were pretty bad. Basically, chance levels; flipping the coin, if you will.

And the reason for that is very straight-forward and led to the development of actuarial tools, and that is this: despite what the media reports, including last week on a couple of shows, news shows, I was watching, unfortunately, the reoffense rates for sex offenders over 5- to 20-year

periods, but definitely within 10-year period, is low enough that the assumptions that go into making risk predictions are essentially violated.

Q. Can you unpack that a little bit, Dr. Plaud?

A. Yes. The base rate of sexual offense recidivism is in an area that is well below 50%. When the base rate of any phenomenon, whether it's sex offending or hitting a baseball, is below 50%, precipitously below 50% depending on how in volume you're measuring it out, then affirmative predictions, meaning someone will do this, become very dicey ... because those assumptions are based on, essentially, that the likelihood, not knowing anything, but just letting a person out, for example, a sex offender out, that there's a good probability that the person's going to reoffend anyway.

Q. Dr. Plaud, this base rate concept --

THE COURT: Are you just about threw with him or what?

MR. GOLD: I've got another 30 minutes, your Honor.

THE COURT: Okay, let's recess. We'll see you at 2:15....

(After a lunch recess commenced at 1:00 p.m., the proceedings reconvened at 2:15 p.m.)

THE CLERK: All rise for this Honorable Court ...

THE COURT: Good afternoon, everybody. Sit down, please. All set to roll?

MR. GRADY: One housekeeping issue, your Honor, on the Hunt trial we did not have closings; we went straight to proposed findings with briefs. We would propose, the parties want to undertake the same course of action here: no closings, go straight to briefs and proposed findings.

THE COURT: Yes, I think so. I think so. If you want me to rethink it, let me know.

MR. GRADY: That's what we would ask the Court.

THE COURT: Yes, I think it's helpful that way. Go ahead.

MR. GOLD: Thank you, your Honor...

Q. Dr. Plaud, are you familiar with an instrument called the Static-99?

A. I am.

Q. And did you employ it when you did your risk analysis in this case?

A. No.

Q. Did you used to use the Static-99?

A. Yes.

Q. Why didn't you use it in this case?

A. Well, in this particular case I would cite two reasons, at least, why I didn't use the Static-99: first, I haven't routinely used the Static-99 since 2005 due to some concerns I developed beginning then with some of the data; but putting that aside, as I said earlier, Mr. Graham is now

59 years old.

Given the base rate data on men who are above age 55, and the assumptions that go into the calculations on the conditional probabilities and expectancy tables for Static-99, which are based on an average age of 34.2 years, and the noted recidivism decreases between 34 years and essentially age 60 ... it violates the assumptions of the Static-99. It totally pulls the rug out from under the bayesian underpinnings of the Static-99 that result ultimately in expectancy tables, so I think it would be in this case, even if the Static-99 data were better than they are, and since October of 2008, there's a lot more concerns and questions about the Static-99, which underscore some of the issues I had done three years earlier when I was having some issues with it; but putting that aside, his age, for a person who's 59 years old, there's currently no actuarial tool that is sufficient for use in making valid extrapolations.

Q. Well, Dr. Plaud, then, what do you do when you communicate risk information to the Court in a case like this?

A. Well, if a person is in an age range such as Mr. Graham, if there is the presence of an underlying sexual disorder, paraphilia, then I would look for evidence that the person has an ongoing inability to control or has serious difficulty

controlling his impulses; I would look at the specific issues relating to risk factors identified in the research that are more acute, that may be predictive of some ongoing difficulties controlling one's sexual behavior, and point to those in my analysis.

Q. Well, can someone who is in the 59, 60-year range ever be considered dangerous in your opinion?

A. Yes.

Q. And what type of evidence or were you just describing the type of evidence that would --

A. Exactly. You would have to have evidence of acute risk factors present, and those can range from, for example, obviously, the easiest one is statements of intent made to either me as the clinician, this has happened, or collateral information that the person has communicated and that I judge has some validity to it; that he is experiencing difficulties or issues in the control of his sexual behavior or intends to engage in certain types of behavior that are high risk ... certainly, that would be a simple straight-forward example of an acute dynamic factor that would override expectations statistically given the age of 59/60 years old, collateral information of behavior, whether the person's incarcerated or not depending on the situation that indicates ongoing difficulties controlling his sexual behaviors; sexually related disciplinary reports, for

example, that would be another example of acute behavioral data.

Q. And, Dr. Plaud, is it true that what we're talking about now is the type of evidence that would counterweight the evidence on age?

A. Right, it would, it would -- it would provide information that would override or tend to override the best information we have on the relationship between age and recidivism.

Q. What is, if you can say briefly, the research on age telling us?

A. Well, the research in the last decade has shown rather conclusively and continues to do so: as one ages, as one gets older, the likelihood that the probability statistically to reoffend in a sexual manner goes down. It's an inverse function of age ... so the older you get, the less likely, all other things being equal, you are to reoffend.

Now, there are certain age cohorts where that effect is seen more prominently. Certainly, in the 50s the effects become -- the slopes of the recidivism curves go down more significantly; after age 60 they're within a 5% -- essentially, within a 5% recidivism ban, so it's very low risk estimate.

Q. Now, we heard testimony that there was conflicting research on the age issue out there; is that correct?

A. That's nonsense.
Q. How is that nonsense?
A. Because there isn't conflicting data. There are a variety of studies from several prominent researchers that show rather conclusively statistically, not arguing any theories or anything, just statistically that age inverse relationship to recidivism.

Now, there have been two studies that have pointed to or asked questions about what type of aging at what time with what -- what age/ages have the more pronounced effect or is age an offense -- this is the only exception I can think of -- is age at the offense more predictive of recidivism than age at release?

However, that's one study that within a year or so was answered in another study to show that there were some statistical errors made in that original study; and when those errors are corrected, the age and offense really isn't a factor.

All the other research from the people who developed the, the actuarial tools, such as Dr. Hanson on down, have shown rather conclusively, and, I mean, without exception, that age matters in the prediction of sexual offense recidivism.
Q. Are you familiar with a study by David Thornton that showed a less marked decline with people with two prior convictions?

A. Yes.
Q. How does that study figure into your opinion?
A. Well, the question is the magnitude of the decline. The decline is still there. The question is magnitude, No. 1; and No. 2, it has to do also with the type of offense.

What you're gonna -- what you find here in this case is, you know, Mr. Graham is not a child molester; and much of that data, research, to the extent that there's equivocation whatsoever focuses more on child molesters than it does on rapists.

And that goes for that study you talked about as well as, for example, the Prentky & Lee study that found two different functions of recidivism as a function of age for rapists versus child molesters, where the child molester variability went out longer and was not a linear function versus rapists, which was essentially a five-year linear function ... so I would say that you need to not have apples-and-oranges comparisons here, just as diagnostically you don't want to have apples and oranges with paraphilias to try to make a rapist a paraphilia, like pedophilia is for child molesters, to look statistically and say: well, this study has mostly child molesters, and we're going to apply it to rapists when there's not data to show that.

MR. GOLD: I have no further questions of the witness.

THE COURT: Okay. Mr. Grady....

MR. GRADY: Just a moment, your Honor. I need to set up. I apologize, your Honor; I'm having one of those nightmares where I left my cross-examination upstairs.

THE COURT: You're giving me a nightmare ... do you know that I've been on the bench 37 years, and I've never had a judge dream, never dreamed that I was a Judge.

MR. GRADY: Lucky you....

THE COURT: No. I always dream that I'm still trying cases, and it's 2:00 and the doctor still hasn't shown up yet, and I got this bastard of a judge who's, you know, going to eat me alive, and I tell him my doctor isn't here to testify, so I sympathize and empathize with you.

MR. GRADY: Who sleeps in that situation, all right.

CROSS-EXAMINATION BY MR. GRADY:

Q. Jim Healy, a 35-year-old social science researcher, has just received multiple sentences of life imprisonment after his third conviction for a series of rapes.

Are you familiar with that sentence, Doctor?

A. Yes.

Q. That is a sentence from a larger factual example in the DSM-IV casebook, right?

A. First edition, correct.

Q. We'll come back to that in a moment, but I want to read a little bit more about this factual discussion --

A. Okay.
Q. -- and then discuss it with you?
A. Correct.
Q. "Jim was reared in a chaotic family. His father was physically abusive towards his mother and toward women in general. Both parents were sexually promiscuous, sometimes in his presence. On at least one occasion as a child he was sodomized by his father. Growing up, feeling alone and unloved, he began fantasizing about the perfect relationship with an ideal woman who he could sweep off her feet.

As time passed such fantasies and urges began to assume an eroticized, obsessional quality. Initially, he would imagine himself coercing unwilling women into sexual activities that she would then come to enjoy.

He would then fantasize a continuing caring relationship. Often, he would masturbate while having these fantasies. Though Jim understood that the scenario in his fantasies was unlikely, he nevertheless began to be preoccupied with sexually exciting urges to act upon those fantasies.

When he was 16" --

MR. GOLD: Your Honor, could I --

THE COURT: Wait. Excuse me.

MR. GOLD: I'd like to object to the reading of this. Just maybe we could have the witness look at it; or if there's a question to be made, it sounds a little like, I

mean, we've talked about this a great deal --

THE COURT: Well, I'll leave him alone. It's cross-examination; I'll let him do it his way, but we want to get as much of the time left as we possibly can. Go ahead.

MR. GRADY: Thank you. We will.

Q. "When he was 16" -- sorry, I'm going to start back at the top of that paragraph: "Though Jim understood the scenario in his fantasies was unlikely, he nevertheless began to be preoccupied with sexually exciting urges to act upon those fantasies.

When Jim was 16, he committed his first rape. After each rape he would promise himself never again; but in time, as his preoccupations and urges were rekindled, he would repeat the cycle.

Although he would often threaten women with a knife to obtain their compliance, he never physically hurt them, and he used the minimal amount of force necessary. Any obvious signs of suffering or anguish would diminish rather than enhance his sexual arousal -- excuse me, allotted arousal; and during the course of each rape, he would invariably throw away his weapon and assure the woman that he did not intend to injure her or cause her harm.

While reading magazines or watching movies depicting females in positions of subjugation or bonding, he would

become erotically aroused, fantasizing that they were enjoying the experience, but he would not become thus aroused if the women seemed to be suffering or in genuine distress.

When tested in prison with a penile plethysmograph, Jim developed an erection when presented with stimuli depicting females in positions of subjugation, but his arousal was diminished if they seemed to be suffering. Laboratory testing of his blood revealed an elevated level of serum testosterone.

Apart from his convictions for rape, Jim has never been convicted or even accused of any other type of criminal activity. He has no history of out-patient/inpatient psychiatric treatment. He has a stable work history. He has never abused alcohol or other drugs."

Have I read that correctly?

A. You have, yes.

Q. Now, we had an opportunity, you and I, to discuss that factual pattern, correct, at your deposition?

A. Correct.

Q. And, in fact, I posited to you that this was an example of an individual whom the authors of the DSM casebook had recognized is properly diagnosed as suffering from paraphilia not otherwise specified, correct?

A. Yes.

Q. And you, in fact, added on, given what I read: Yes, and I probably would too; is that correct?
A. Yes.
Q. Now, I want to see if we can assist the Court in understanding how we get to that diagnosis from these facts.
A. Okay.
Q. And I think there are two questions at issue: the first is whether the diagnosis of paraphilia NOS can ever exist, correct?
A. Right.
Q. And there's a separate question, is there not, about whether it would apply to Mr. Graham?
A. Well, I think the first one is a given, but the second one definitely is a question.
Q. Okay. Well, when you say "it's a given," the diagnosis certainly exists, correct?
A. Exactly. It doesn't matter what I think. There is a diagnosis called paraphilia not otherwise specified.
Q. Okay, and there are unquestionably --
THE COURT: Which is not in the DSM?
THE WITNESS: Which is in the DSM.
THE COURT: Which is in the DSM?
THE WITNESS: It doesn't refer to any particular type of paraphilia; it's just not -- what I was describing, Judge, earlier in the sense that you can put anything in

there.

THE COURT: Okay, I remember.

Q. Now, I just want to talk a little bit for the record purposes about the book we were reading from?

A. Yes.

Q. I'm going to show you the book we've previously had in evidence -- well, actually, we previously discussed; none of this is new.

Can you tell me what this book that I read from is entitled?

A. Yes. That's the first edition of the casebook for the DSM-IV-TR, and you can see the other verbiage: it's a learning companion.

Q. Okay, and who are the editors of this book?

A. The same editors essentially and advisors that contributed to the DSM-IV themselves.

Q. Just for clarity purposes, Robert Spitzer was the editor-in-chief of the DSM-III and DSM-III-R, correct?

A. Yes.

Q. And Miriam Gibbons contributed to the writing, I believe, of the global assessment and functioning that is located in the DSM-IV?

A. Right, she was an advisor.

Q. And Andrew Skodol was a member of one of the working groups that contributed diagnosis to the DSM-IV, is that

correct?
A. Correct.
Q. And Janet Williams was a member of the DSM-IV Task Force?
A. Right.
Q. And Michael First was, as to the DSM-IV, the editor of the text?
A. Correct.
Q. And as to the DSM-IV-TR, he was the editor-in-chief and cochair, correct?
A. Correct.
Q. Okay. Now, you mentioned this was the first edition; are you aware of another edition?
A. I'm aware of a second edition, yes.
Q. Okay. What is your understanding of that edition with respect to the example of Jim?
A. It is my understanding that that was not concluded. Jim's case was not included in the second edition.
Q. And why was that, do you know?
A. I wasn't privy to the discussions so I don't know exactly why, no.
Q. Okay. I'm just going to show you very quickly another book; do you recognize that?
A. Thank you. Yes, the treatment companion, I have seen it.

Q. Okay. The treatment companion of the DSM-IV-TR casebook?
A. Right.
Q. And that is written by, hopefully, we can read it, the same people?
A. Correct.
Q. Robert Spitzer, Michael First, Marian Gibbons, and Janet Williams, correct?
A. Yes.
Q. And just with respect to the claim that the case of Jim is not in the treatment companion book -- let me back up for a minute. This is entitled The Treatment Companion to the DSM-IV casebook, correct?
A. Right.
Q. It's meant to be a companion to it, not a superseding edition, correct?
A. Oh, absolutely. It's not the DSM-IV-TR.
Q. Well, I'm talking about the casebook.
A. Okay.
Q. This is not a superseding edition of the casebook, correct?
A. No.
Q. And it is directed, unlike the original casebook, to treatment rather than diagnosis, correct?
A. Correct.

Q. Okay. Now, you actually have a copy of the casebook, the original DSM-IV-TR casebook?

A. I do.

Q. And you yourself use it for the purpose of checking up on diagnosis, correct?

A. Well, not really. I mean, I have used it more for educational, working with students is really the main reason, but, I mean, I have referred to it, sure.

Q. Well, let me see if you agree with this description; it was from perhaps an authority you would consider very good. "The authors of the casebook have taken real-life examples and facts, and they have applied the diagnostic criteria of the DSM-IV text revision to provide correct diagnoses, and they have given an analysis of the background facts that you do not get from the DSM-IV-TR itself."

Would you agree with that description?

A. Sure.

Q. Okay. And that's exactly the description you gave in your deposition, correct?

A. That's a good one.

Q. Okay. And it is, in fact, used to compare case examples in the book with real-life diagnostic situations?

A. Right.

Q. And, in fact, you have used it yourself for that purpose?

A. Yes.
Q. Just taking a moment, your Honor, I'm skipping questions ... now, you would agree that Jim is properly diagnosed with paraphilia NOS, correct?
A. I would agree that that is -- yes, that that diagnosis could be made because of the wealth of information specifically contained in the narrative that you read earlier. Although, I would have a question about sexual sadism, but the words are really tailored so I would agree.
Q. Okay. At your deposition you were asked: "And the authors of the DSM casebook recognized that it's that example, Jim, as properly diagnosed as paraphilia not otherwise specified, have they not?" And your answer was: "Given what I have read, yes, and I probably would too if I had those issues demonstrated"?
A. Exactly. In other words, they're saying that the person experienced x, y, and z. There's an eroticized urge and fantasy about coercing a woman sexually. It's laid out in great detail in the text that you read.
Q. So with respect to that factual situation, we have an individual who experiences deviant sexual arousal to coercive sex, correct?
A. Right.
Q. That is properly diagnosed under the DSM, under the category of paraphilia NOS, correct?

A. I would agree.
Q. Now, I indicated that I wanted to see to assist the Court in figuring out how we get to that diagnosis ... so can you tell me what would be used to reach a diagnosis of paraphilia NOS?
A. You would look in the DSM-IV-TR that you're holding in your hand.
Q. Excellent. And, now, on direct you mentioned that you would have a different diagnosis based on whether something was done in treatment or in a forensic setting, correct?
A. No, I don't think that's what I said.
Q. You indicated that there could be -- you would offer a diagnosis in treatment regarding the NOS category?
A. Right.
Q. But you might not offer the same diagnosis in a forensic setting, correct?
A. Correct. If the strength of the diagnostic criteria were not there, that's correct.
Q. Which version of the DSM am I holding? Am I holding the courtroom version or the treatment version?
A. You're holding the one and only version.
Q. Okay, so there's no different DSM for treatment; there's no different DSM for forensic settings, correct?
A. No. Although, there are cautionary statements in that book about the use of it in forensic settings.

Q. I'm sorry, I must have mis-asked the question. There is no DSM specifically for treatment sessions: yes or no?
A. Correct.
Q. And there is no DSM specifically for courtroom settings: yes or no?
A. Correct.
Q. Okay. Now, if an individual with Jim's symptoms came to you, you would not look at Jim, and say: You're fine, go home; nothing we can do for you, correct?
A. I would agree with that.
Q. Jim has a problem?
A. Yes.
Q. Okay. And the question is how do we determine whether Jim's condition meets the diagnostic criteria under the DSM, correct?
A. In part, yes.
Q. Okay. That's where we'd go to see if he meets the definition of the disorder?
A. Yes.
Q. Okay. Now, Jim's problem appears to be based upon deviant sexual arousal, correct?
A. It would appear given the description that that would be correct, yes.
Q. Is there a section of the DSM or a series of disorders that applies to individuals with deviant sexual arousal?

A. Yes.
Q. What is or what are those called?
A. Sexual disorders.
Q. Okay. Is there, within the category of sexual disorders, disorders that are specifically characterized by deviant sexual arousal?
A. Yes.
Q. Okay, and what are those?
A. The paraphilias.
Q. Paraphilias ... just would you agree with this: the core diagnostic construct that forms the basis of the paraphilia category is that the person becomes sexually aroused in response to stimuli considered to be abnormal, correct?
A. That's essentially correct.
Q. And Jim's erotic arousal to nonconsenting sex is abnormal, correct?
A. Both abnormal and illegal, yes.
Q. But it is abnormal, correct?
A. Yes.
Q. Now, so it seems to me, and let me know if you would agree: if we wanted to know whether Jim had a diagnostic criteria in the DSM, we would want to look in the paraphilia section, correct?
A. Yes.

Q. And where is that located, if you know?
A. On what page?
Q. If you could look at Government Exhibit 21.
A. Yes.
Q. Take a look through that and let me know whether you recognize what is within Government Exhibit 21 in evidence?
A. It does have a copy of the paraphilia section, beginning at Page 566 of the DSM.
Q. Okay. Now, how many paraphilias are there?
A. How many are there?
Q. Yes.
A. Well, there are a number of predefined ones, ones that are most salient, most encountered; but as I indicated in my direct testimony, the universe of potential paraphilias can be great.
Q. Okay.
A. A person, if it's demonstrated whether by their physiological arousal, their self-report, collateral data, can and are aroused to many different things that aren't defined specifically in the DSM.
Q. Okay. The universe of deviant sexual arousals that might give rise to a paraphilia diagnosis are virtually limitless, correct?
A. I would say so, yes.
Q. And among those deviant sexual arousals that can give

rise to a diagnosis of paraphilia under one of these categories would include deviant sexual arousal to coercive sex?

A. It's possible. How likely it is is another question, but it's certainly, as I said, possible.

Q. Within the universe of paraphilias that can give rise to a diagnosis of paraphilia within the DSM, within that universe is deviant sexual arousal to coercive sex, correct?

A. It's possible.

Q. Is it within the universe: yes, or is it not within the universe: no?

A. Well, I think it's somewhat south of Alpha Centauri, but it's in the universe somewhere.

Q. Yes?

A. Yes.

Q. It was a long time to get to that, yes.

MR. GOLD: Objection, your Honor.

THE COURT: We'll let it stand. I don't have to rule on that....

MR. GRADY: Withdrawn, your Honor. I apologize....

Q. Now, you mentioned there are specifically named paraphilias, correct?

A. Correct.

Q. Pedophilia, which is what?

A. That's a disorder pattern of sexual interest in

prepubescent children.
Q. Okay. We would look at that in Jim's case, and we would conclude Jim does not qualify for pedophilia, correct?
A. Well, I mean, from the limited -- from the description I would say I agree with you, but it's certainly not -- it's certainly possible if I had more information, but just relying on the four paragraphs, I would agree.
Q. Okay. Relying upon the factual information relayed in the casebook example, we would conclude that pedophilia is not an appropriate diagnosis, correct?
A. Correct.
Q. Another potential paraphilia diagnosis would be sadism?
A. Correct.
Q. Frotteurism?
A. Correct.
Q. Fetishism?
A. Correct.
Q. Masochism, transvestic fetishism?
A. Yes.
Q. Voyeurism and exhibitionism, correct?
A. Yes.
Q. That's every listed paraphilia, correct?
A. Correct.
Q. And Jim's example based on the information you have does not fit within any of them, correct?

A. With the information, it does not, with the caveat of more -- I would want more exploration on sexual sadism; but having said that, it does not neatly fall into any of those other defined paraphilias.

Q. Let me digress completely one moment from my preplanned questions. When you say, "I would like more information on sexual sadism," does that mean you'd ask questions about it in a clinical interview or something like that?

A. Correct.

Q. So you'd make specific questions about sadistic urges/behaviors that might be sadistic, correct?

A. Correct.

Q. Okay. Backing up, Jim's example does not fall within any of the eight specified paraphilias in this section of the DSM, correct?

A. Correct.

Q. What are we to do with Jim? Where do we go next?

A. Well, diagnostically, you'd get as much information about what specifically the urges are, as the casebook illustration goes into in some detail, and the chronicity of it; in other words, how long has it gone on for, and that's where a paraphilia not otherwise specified would come into the analysis.

Q. Uh-huh. A paraphilia not otherwise specified, where is that in Exhibit 21?

A. It is on page -- beginning on Page 576.
Q. I'm just going to read from the DSM Page 576; Code 302.9, what's that?
A. That's a diagnostic code for coding purposes.
Q. For billing?
A. Well, among other things, yes. It is a billing code as well.
Q. The title is paraphilia not otherwise specified, correct?
A. Correct.
Q. And under that it reads: "This category is included for coding paraphilias that do not meet the criteria for any other specific categories."
Have I read that correctly?
A. You have.
Q. Okay. And with respect to the example we've provided of Jim, Jim does not meet the criteria for any of the specified categories, correct?
A. Correct.
Q. Okay. So the first essential criteria for putting something into the paraphilia NOS category is that it not be specified elsewhere in the paraphilia category, correct?
A. Right.
Q. So the first thing something needs to have to qualify for this diagnosis is that it not be in the DSM anywhere

else, correct?
A. Well, not --
Q. Not be in the paraphilia section?
A. Okay, not being in the paraphilia section; however, it can -- some of the diagnostic criteria can be in there, but they don't meet all of them, and I think I spoke to that on great extent in my direct examination.
Q. We'll come -- sorry, I didn't mean to interrupt you.
A. No. I'm just saying if the person, for example, meets a number of the criteria of one of those other paraphilias that you named, but not all of them, that's a potential paraphilia not otherwise specified as well.
Q. Well, but, certainly, this diagnosis would include paraphilias that are not mentioned in the specified categories?
A. True.
Q. I'm going to read on under the paraphilia NOS in the DSM-IV, Page 576: "Examples include but are not limited to telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on parts of the body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas) and urophilia (urine)."
Have I read that correctly?
A. You have.
Q. Okay, and what we have here is a list of examples, that

is, by the words of the DSM, not exclusive, correct?
A. I'm sorry?
Q. You have a list of examples --
A. Oh.
Q. -- but it is not an exclusive list, correct?
A. Yes.
Q. Okay. Now, there is an NOS category for virtually every class of disorders; is that correct?
A. That's right.
Q. I'll come back to the paraphilia not otherwise specified in a moment ... I'm going to show you Page 939 of the DSM. Typically -- I apparently left my highlighter at home -- that is the listing for --
THE COURT: Do you want to borrow one? Do we have one here?
Q. I'm just going to direct your attention to the highlighted listing in the bibliography -- well, strike that. Do you recognize what I've shown you on the screen as the bibliography of the DSM-IV Text Revision?
A. It looks like the index.
Q. Well, we'll start with the book.
A. Yes.
Q. We'll start with the book. Go to the back. I'm in another one of those dream modes ... all right. In the back, beginning at Page 933, there is a title; what is it?

A. "Index."
Q. Okay. I'm going to show you a Page 939. Showing you Page 939 of the DSM, does that appear to be a portion of the DSM-IV Text Revision Index?
A. Yes.
Q. What is the highlighted entry?
A. "Not otherwise specified."
Q. And approximately how many other "not otherwise specified" categories are there in the DSM besides that for paraphilias?
A. Many.
Q. Over 40?
A. That would be right.
Q. Now, I'm just going to come back to the beginning of the DSM. Sorry, I apologize to the Court. I'm going to go back to the beginning of the DSM.
A. Okay.
Q. Page 1, what's the title of the section beginning on Page 1?
A. "Use of the manual."
Q. Okay, and we'll go to Page 4. Now, you would agree the section beginning at Page 4 of the DSM-IV Text Revision is a general description by the authors and the writers of the DSM-IV Text Revision on how to use the DSM-IV Text Revision, correct?

A. Correct.
Q. And --
MR. SINNIS: May I give him a copy so he can follow along, if Mr. Grady is going to go from page to page?
THE COURT: That would be helpful. Don't you think so?
MR. GRADY: Sure, I can give him a copy.
MR. SINNIS: No, I'll give him a copy.
MR. GRADY: That's fine.
Q. Directing your attention to Page 4, is Page 4 a portion of the beginning of the DSM-IV Text Revision that describes how to use the DSM-IV diagnostic categories?
A. Yes.
Q. Okay. And within that on Page 4 is a section entitled: "The use of the not otherwise specified categories," correct?
A. Correct.
Q. And it begins: "Because of the diversity of clinical presentations, it is impossible for the diagnostic nomenclature to cover every possible situation."
Is that correct; have I read that correctly?
A. You have.
Q. And do you agree with that?
A. I do.
Q. Okay. "For this reason, each diagnostic class has at least one not otherwise specified category, and some classes

have several NOS categories," correct?
A. Correct.
Q. Now, I've read that correctly?
A. You have.
Q. And you agree with that, correct?
A. I do.
Q. All right. "There are four situations," it goes on, "in which an NOS diagnosis might be appropriate," correct?
A. Right.
Q. The first diagnosis, there's four bullet points there?
A. Yes.
Q. In deference to my brother, why don't you read the first bullet point for us?
A. Yes. "The presentation conforms to the general guidelines for mental disorder in the diagnostic class, but the symptomatic picture does not meet the criteria for any of the specific disorders.

This would occur either when the symptoms are below the diagnostic threshold for one of the specific disorders or when there is an atypical or mixed presentation." That's what I was talking about earlier.
Q. Now, with respect to this first bullet point, when we refer to Jim, are we -- strike that.

Are we following that bullet point of these instructions when we place Jim into the paraphilia NOS category?

A. No.
Q. Okay. Can you read onto the next --
A. "The presentation conforms to a symptom pattern that has not been included in the DSM-IV classification, but that causes clinically significant distress or impairment. Research criteria for some of these symptom patterns have been included in Appendix B. Criteria sets and axis provided for further study; in which case, a page reference to the suggested research criteria set in Appendix B is provided."
Q. And with respect to placing Jim within the paraphilia NOS category, is this instruction that you've just read the manner in which we're using the NOS category?
A. No.
Q. All right. Can you continue?
A. "There is uncertainty about etiology; that is, whether the disorder is due to a general medical condition, is substance induced or is primary."
Q. Okay. Is that the bullet point that you would follow in placing Jim within the paraphilia NOS category?
A. No.
Q. Okay, and read the fourth?
A. There is insufficient opportunity for complete data collection; for example, an emergency situation or inconsistent or contradictory information, but there is enough information to place it within a particular

diagnostic class. For example: the clinician determines that the individual has psychotic symptoms but does not have enough information to diagnose a specific psychotic disorder."

Q. Okay. And is that the class in which you would testify that we would be placing Jim in, the paraphilia NOS category?

A. Not really.

Q. Okay. There is additionally a section of that introduction that indicates that the paraphilia NOS category may be used to indicate diagnostic uncertainty?

A. Right.

Q. Is that where you would place Jim in the category of paraphilia NOS?

A. No.

Q. Okay. Let's come back to the paraphilia NOS diagnosis for a moment; we'll put Jim aside for a minute and come back to 576 of the DSM-IV Text Revision ... one of the ways, you would agree, that the authors of the DSM-IV Text Revision had indicated the not otherwise specified category can be used is where presentation conforms to the general guidelines for the mental disorder in the diagnostic class, but the symptomatic picture does not meet criteria for any of the specific disorders, correct?

A. Yes.

Q. Now, paraphilias, as we've discussed, concern deviant

sexual arousal, correct?
A. That's essentially correct.
Q. Now, just coming back to the paraphilia NOS, there are examples in that category, correct?
A. Yes.
Q. We'll take, for example, obscene phone calls, telephone scatologia?
A. One of my favorites.
Q. Where in the DSM am I to find the criteria for diagnosing that?
A. There are no specific criteria for the diagnosing of telephone scatologia. You rely on the general criteria beginning on Page 566 in the description of paraphilias.
Q. So that nowhere in the DSM does it tell me how many phone calls I have to make to qualify for the diagnosis, correct?
A. Right.
Q. Nowhere in the DSM does it tell me how frequently I'd have to make those phone calls week to week, month to month, year to year; it does not tell me that, correct?
A. No, it doesn't, with the understanding that the six-month period that I discussed earlier is a general criteria for any of the paraphilias.
Q. Whatever frequency with which I engage in telephone scatologia would have to meet the six-month criteria you

just identified?
A. Correct.
Q. But it doesn't tell me if it's within that six months specifically how frequently you would have to engage in the behavior?
A. Correct.
Q. It doesn't tell me how many calls a day, correct?
A. It does not.
Q. Okay. With respect to klismaphilia, it's somewhat disturbing, it doesn't tell you how many enemas on a given day an individual would have to have, correct?
A. True.
Q. It doesn't tell you how frequently they would have to do it, correct?
A. True.
Q. Now, should we infer from that, the absence of these criteria in the DSM, that these are not properly diagnosed under the category of paraphilia NOS?
A. I don't understand the question.
Q. Sure. There has been argument made that there are no set criteria for some paraphilia NOS diagnoses; do you understand that to be the case? Do you understand to have testified that there are no criteria for the diagnosis of paraphilia NOS as it applies to coercive sex?
A. That's true, there isn't.

Q. All right, and you have endorsed the notion that that cannot be a proper paraphilia NOS diagnosis because the DSM does not provide specific criteria for that, correct?

A. The diagnosis paraphilia NOS (nonconsent) that I was referring to, correct.

Q. But you believe that paraphilia or among many reasons, you believe paraphilia NOS (nonconsent) cannot be a diagnosis because there are no specific criteria in the DSM, correct?

A. I can't answer that yes or no. I --

Q. That's fine.

A. Referring to the diagnosis itself, in the use of the term --

Q. I'm sorry, Doctor, did I ask you to explain?

A. Okay.

MR. GOLD: I would object to the argument, your Honor.

THE COURT: No, he's trying to confine the witness; he's entitled to that.

Q. Now, with respect to -- well, let's come back to this coprophilia, how would one have to manipulate the feces according to the DSM to qualify of coprophilia under the category of paraphilia NOS; where are the criteria in the DSM?

A. Page 566 under the diagnostic features of paraphilias.

Q. Okay. So in order to help the Court, if we were going

to look to diagnose someone with paraphilia NOS, we would go back to the generalized criteria for paraphilia listed on Page 566, correct?

A. Yes.

Q. And we would look to those criteria and let me see if I can identify it, okay? I'm going to read some portions of that, and you can tell me if those are the criteria? I'm going to start with the "diagnostic features."

"The essential features of paraphilia are recurrent, intense, sexually-arousing fantasies, sexual urges, or behaviors generally involving," and they give three things: "one, nonhuman objects; two, the suffering or humiliation of one's self or one's partner; or, three, children or other nonconsenting persons that occur over a period of six months, Criterion A."

Have I read that correctly?

A. Correct.

Q. And that is essentially the first criteria of making paraphilia NOS diagnosis, correct?

A. Correct.

Q. Okay. Now, previously you testified nonconsent paraphilia -- well, strike that.

In the context of critiquing the diagnosis of paraphilia NOS (nonconsent), you've indicated or you testified, if you recall, that nonconsent is not in the DSM?

A. That diagnosis is not in the DSM, correct.
Q. Your exact testimony, I believe, was nonconsent is not in the DSM?
A. No, the term is in the DSM; it's used differently than the Doren term is.
Q. The term is in the DSM, correct?
A. Yes.
Q. The term nonconsenting is right there in Criterion A that you've identified as being the first criteria we would use to diagnose paraphilia NOS, correct?
A. Correct.
Q. Now, you also mentioned that nonconsenting doesn't mean nonconsenting? It has a limited meaning; it's only meant to apply to certain of the paraphilias, correct?
A. Well, I mean, I can't answer correct, and I disagree with the way you've phrased your question.
Q. You've testified previously -- I'll rephrase it.
A. Thank you.
Q. -- that the nonconsent that is used in that sentence doesn't mean nonconsent generally?
A. It has a specific meaning that I think is different from the Doren meaning in this book, correct.
Q. It only means nonconsent for sadism and what other --
A. No, children are nonconsenting.
Q. It says "children"?

A. Children or other nonconsenting.
Q. So children are within the --
A. So that is sadistic behavior, exhibitionistic behavior, voyeuristic behavior, behavior which involves sexual arousal and aberrant sexual behavior where there are nonconsenting victims, and I described it in some detail, for example, at a park with an exhibitionist.
Q. Okay, but it's not meant to apply to nonconsenting rape victims?
A. Well, it's not the reason it's there; I'll say that.
Q. Okay. Well, where in the DSM can I read that nonconsenting as it exists in Criterion A does not apply to rape victims?
A. It doesn't say.
Q. It doesn't say that in the DSM, correct?
A. It's silent on that issue.
Q. Well, let's be clear: the DSM in its text does not say, as you testified earlier, that the term nonconsenting applies only to certain paraphilias as it is used in Criterion A?
A. No, that's the discussion that went around the use of that term, as that article pointed out, but I will agree that it's silent on exactly the attribution of the term, yes.
Q. Well, again, remember -- you would agree that the DSM does not say anywhere in its text that the term nonconsent,

as it is used in Criterion A on Page 566, nowhere in the DSM does it say that does not apply to rape victims? That's correct, is it not?

A. It does not mention the word "rape."

Q. So, yes, that is correct?

A. Yes, that is correct.

Q. I'm just going to direct your attention to a little bit further down. The second half of that paragraph is dedicated to a little paragraph entitled: Criterion B, correct?

A. Yes.

Q. And, generally speaking, the remainder of those sentences are the second criteria for making a diagnosis of paraphilia NOS, correct?

A. Correct.

Q. Okay. And the particular sentence that would apply to paraphilia NOS begins: "For the remaining paraphilias," correct?

A. Yes.

Q. Okay. So for the second criteria we would look to, to make a diagnosis of paraphilia NOS, we would look at: "For the remaining paraphilias, the diagnosis is made if the behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of function." Correct?

A. That's what it says, correct.

MR. GRADY: If I could just have a moment, your Honor....

Q. Now, having discussed all of that, I'm going to come back to Mr. Healy, Jim Healy, in the casebook ... and just going to -- now, in this casebook the authors have provided a description of how they have applied the DSM Text Revision diagnostic criteria to the factual situation, correct?

A. Yes, to looking at an example, yes.

Q. They've given their opinion, correct? It's not the American Psychiatric Association, this is not the DSM, correct?

A. No, this is whoever the author was particularly of this section.

Q. Okay. And that author indicates Jim, and I'm just going to quote from it: "Jim experienced recurrent eroticized urges and fantasies about coercing women sexually."

Have I read that correctly?

A. You have.

Q. And would you agree that based upon that fact pattern, Jim experienced recurrent eroticized urges and fantasies about coercing women sexually --

A. That's what it says.

Q. -- you would agree? Would you agree with that statement: "Jim experienced," based on the facts you read, "recurrent eroticized urges and fantasies about coercing

women sexually"?

A. That's what it says, yes.

Q. "Such fantasies and urges have been present for many years, and he had been" -- excuse me, "and he had repeatedly acted on them."

I've read that correctly, have I not?

A. Yeah.

Q. And you would agree that of the fact pattern you described, this is an actual description of, correct?

A. I'm sorry, I don't quite understand. That's what it says.

Q. Sure.

A. That's an example. It's a case vignette. You're reading it accurately, correct.

Q. Okay, and what I'm tempting to discern is if you agree with the statements being made by the author about the case vignette, so when I say the author states that such fantasies and urges have been present for many years, and he had repeatedly acted upon them, I ask you: has the author accurately summarized the fact pattern?

A. I have no idea. This is a hypothetical case that they're inventing. I don't agree or disagree with it. I'm saying you read it the way it is in the text.

Q. Okay. But we can all read the facts, correct?

A. Yes.

Q. But not all of us are psychologists like you, correct?
A. True.
Q. And when you read a certain fact pattern, you bring a certain expertise to bear, correct?
A. True.
Q. Now, I can read the facts and I can read what the author says, but I can't know from that whether you, bringing your expertise to bear, agree with the author of this document; that's what I'm attempting to discern?
A. Well, and you're going over this expert's head because it's not in my power to agree or disagree; it is what it is. It's being --
THE COURT: I think what he's asking you: does it add up to something? Is that what you're basically asking?
MR. GRADY: Well, I wanted to know to the extent that the author offers his discussion and opinion on this case, your Honor, the extent to which Dr. Plaud agrees with it, and I was going through it sentence by sentence, but I can certainly try to wrap it up if Dr. Plaud is having difficulty understanding the concept; it's not a problem.
THE COURT: Move onto something else then....
Q. Dr. Plaud, the author of this vignette has concluded that Jim's disorder would be coded as paraphilia not otherwise specified under the DSM-IV Text Revision, Page 576, correct?

A. Yes.
Q. And you've previously testified you agree that it would be so coded or so diagnosed?
A. Assuming the facts as they are presented that would be the most appropriate diagnostic criteria, that category, yes, for Jim.
Q. Now, is there any confusion that the author of the casebook was unaware that paraphilic coercive disorder was declined or was rejected as a separate paraphilia diagnosis?
A. I have no idea.
Q. Okay. Well, let's just move up one sentence.
"During the development" -- I'll ask you if I've read this correctly: "During the development of DSM-III-R the term paraphilic coercive disorder was suggested for this particular kind of paraphilia, but the category has never been officially recognized."
Have I read that correctly?
A. You have.
Q. And does that inform you about whether the author of this vignette who concluded that paraphilia NOS is an appropriate diagnosis, does that inform you as to whether he is aware whether paraphilic coercive disorder was rejected?
A. Correct.
Q. He is aware, correct?

A. He would appear to be, yes.
Q. And notwithstanding that he is aware that paraphilic coercive disorder was previously rejected in the DSM-III Revision, he nonetheless concludes that the appropriate diagnosis here is paraphilia NOS, correct?
A. Correct.
Q. Now, you would agree that in an individual who has a paraphilic sexual attraction to nonconsenting partners, it is possible to make a diagnosis of paraphilia NOS, correct?
A. It is.
Q. And, in fact, the case illustration is an example of such an individual?
A. It is, because it specifies the essential features of paraphilia letter by letter.
Q. Okay, and just so there is no possibility for confusion: there is a diagnosis for paraphilia NOS that can be properly made where the paraphilia in question is a sexual interest in engaging in sexual acts with nonconsenting partners: yes or no?
A. It's possible. Not probable, but possible, yes.
Q. Thank you. And, in fact, you indicated in your testimony, both today and in deposition, that you have been prepared on four or five occasions to make such a diagnosis based upon paraphilic interest in nonconsenting sex, correct?
A. Yes, I certainly have encountered it, not with this

amount of detail, but, yes, I would agree, as I've testified to, but it's such a small number, and that's the most critical issue. It's so rare.

Q. I mentioned there were two questions.

A. Okay.

Q. And it seems to me that the first question is whether a diagnostic model or a disorder exists, correct?

A. Yes.

Q. And the second question is whether it applies to Mr. Graham, correct? And we're going over right now whether the disorder exists, correct?

A. Yes.

Q. And, in fact, it is your testimony and you agree that that disorder exists as we've just discussed?

A. Yes.

Q. Now, as you pointed out, there remains in this case the question about how that diagnosis does or does not apply to Mr. Graham, correct?

A. Yes.

Q. Just a couple more questions on this issue, Dr. Plaud ... you discuss the issue of paraphilia NOS nonconsent in your report, correct?

A. That's correct.

Q. Okay. And you indicate in rather unequivocal language that the diagnosis of paraphilia NOS nonconsent does not

exist, correct?

A. That's right. It's made up.

Q. You have indicated that, in fact, with no less equivocal language that it is a made-up diagnosis, correct?

A. Exactly, it is.

Q. But there is, nonetheless, a paraphilia NOS diagnosis that can be properly made based upon a deviant sexual arousal to nonconsenting sex, correct?

A. I agree with you and that's the key, based on....

THE COURT: Based on what?

THE WITNESS: Based on evidence of the underlying arousal that is focused on nonconsenting aspects to sexual arousal.

You can label any behavior with a nonconsent validly. I'm not disputing to any degree that NOS should or shouldn't be there. I think it should be in the DSM.

The question is: there's another pseudodiagnosis, Judge, called paraphilia NOS (nonconsent) with criteria that's not in the DSM that we've just been discussing, developed by one person named Dennis Doren, and published in a book in 2002; and that's what's being used by some clinicians to make diagnoses and give them some credibility, in the absence of the demonstration of the underlying sexual arousal disorder. That is the key issue.

What we've been discussing here is the example by a

hypothetical man named Jim where they can see in the text every issue, forget about the nonconsent -- or sex with nonconsenting persons, they're just going down in a bullet-like fashion saying that it's recurrent and intense sexual fantasies, urges, and behaviors towards this type of sexual behavior ... that's a paraphilia NOS.

Q. Well, Dr. Plaud, to be clear, the diagnosis of paraphilia NOS may be made based upon a deviant sexual arousal to non -- excuse me, to coercive sex, right?

A. Sure.

Q. And what you take issue with is the label: paraphilia NOS with the parenthesis (nonconsent) inside the parenthesis, correct?

A. Well, I do, but that's just the beginning ... because there is a separate set of criteria designed and developed by one individual that tries to go around the issue of the deviant arousal and specified other factors that you can use to make such a diagnosis; that's the phony part.

Q. Great, thank you. Where -- in your report I see a page-and-a-half dedicated to -- it's Exhibit 27, if you want to look; I see a page-and-a-half dedicated to paraphilia NOS (nonconsent) does not exist.

Would you agree with that?

A. I have one -- two paragraphs dedicated to that specific issue on Page 9.

Q. Okay. Two full paragraphs dedicated to the assertion that paraphilia NOS (nonconsent) does not exist, correct?
A. Yes.
Q. Where -- well, strike that. Nowhere in your report does it mention that paraphilia NOS may be properly diagnosed based upon a deviant sexual arousal to nonconsenting sex, correct?
A. I don't have that and I wouldn't put that in there; there's no reason for it, but, yeah, true.
Q. Nowhere in your report is that acknowledgment, correct?
A. No, I talk about the V code issue and how to come to terms with it.
Q. Well, let's be clear: nowhere in your report does it say that even though paraphilia NOS (nonconsent) which I've dedicated two paragraphs to does not exist, there is certainly a diagnosis of paraphilia NOS that is properly applied when the deviant sexual arousal issue is to noncoercive sex?
A. That's true, with the caveat that I do discuss paraphilia NOS specifically.
Q. Okay, but you never acknowledge that there is a proper paraphilia NOS diagnosis that can be applied to individuals who experience deviant sexual arousal to nonconsenting sex; it's nowhere in your report, correct?
A. That's correct. I don't discuss any of the -- any

specifics, because as you said, there is a universe of potential issues. I don't discuss potential sexual interest in tables or chairs or, you know, bedroom furniture, or, you know, there's a universe of possibilities.

Why would I even want to put that into the report?

Q. So you wouldn't -- that's fine, I understand.

In your view the potential diagnosis of paraphilia NOS that applies to individuals who derive sexual pleasure from noncoercive sex, from rape, doesn't belong in your report?

A. If it were in evidence in the case, it would be in my report, but there is no evidence in this case of any of that being here.

Q. So your testimony is there is no need to have any discussion about paraphilia NOS (nonconsent) -- strike that. Excuse me.

There's no need to have any discussion in your report about paraphilia NOS based upon deviant sexual arousal to rape or nonconsenting sex?

A. Absence of evidence, no, there isn't. Other than the description that I do give in my report in talking about what paraphilia NOS is, talking about examples given in the DSM, talking about rape-related paraphilias that may have relevance such as sexual sadism, and then talking about the Doren diagnosis, that's -- I'm trying to talk about, dissect the important issues.

Q. Well, in your book then, let's agree: in your view it was important to dedicate two paragraphs to the fact that paraphilia NOS (nonconsent) does not exist, correct? You dedicated your time to the important issues?

A. No, that actually is -- it's in two sentences. I mean, in most of the large paragraph I talk about the V codes. I'm talking about the V codes in the DSM.

Q. You're talking about V codes in the context of refuting the diagnosis of paraphilia nonconsent, correct?

A. No, I'm talking about that is the place where in the DSM it's dealt with more traditionally than what your suggestion is....

Q. Well, so you indicated previously you only needed to put in your report what was important, correct?

A. True.

Q. And you put in your report at least two paragraphs about paraphilia NOS (nonconsent) not existing, correct?

A. True.

Q. And you put nothing in your report about acknowledging that paraphilia NOS can be properly diagnosed where an individual has a deviant sexual arousal to noncoercive sex, correct?

A. To noncoercive?

Q. Excuse me, to coercive sex.

A. I did not put that in, correct.

Q. You mentioned other diagnoses that you thought might apply but the criteria weren't met, correct?
A. True.
Q. You mentioned sadism?
A. I did.
Q. And you mentioned that sadism is a recognized paraphilia; it would be a possible diagnosis, but it's not met, correct?
A. Correct.
Q. But you do not undertake any such analysis with respect to the paraphilia NOS diagnosis based upon deviant sexual arousal to coercive sex, correct; it's not there?
A. It's not there because it would -- on a case-by-case basis, given its low frequency, I mean, as I said....
Q. Now, Doctor, you included a bibliography to your report, correct?
A. I did, yeah.
Q. And in your bibliography you cited to relevant works that were important to your decision, correct?
A. True.
Q. And they're cited in the bibliography because they were important to your decision, correct?
A. Well, not only in this case.
Q. Well, they played a role?
A. Yes. I mean, those are some of the salient research

papers in the last couple decades.
Q. And were you familiar with the DSM casebook and the example of Jim Healy when you drafted this report?
A. I certainly had read it a number of years ago, so I was aware of it. Really, it's through the net; it's not research, so --
Q. Not mentioned in your bibliography?
A. I was aware of it, and it's not in my bibliography because I'm citing more authoritative, mostly research articles in there.
Q. Great. Is there any of those more authoritative, mostly research articles, that you cite in your bibliography that have anything to do with the diagnosis of paraphilia NOS?
A. Well, I have some references to books that talk about paraphilia NOS, sure, including some of my own publications where I discuss that.
Q. Do you recall in your deposition when I asked you quote -- why don't I just show it to you -- "Are you aware -- well, are you aware of any peer-reviewed journals that support the descriptor nonconsent within the context of a paraphilia NOS diagnosis?" Your answer was: "No" --
A. That's correct.
Q. -- right? I'm just going to show you an item and tell me if you know what this is?

A. Yes.
Q. What is it?
A. It's a review article written by Michael First and Robert Halon, published in the Journal of the American Academy of Psychiatry and the Law.
Q. Is the Journal of American Academy of Psychiatry and the Law a well-recognized journal?
A. Very well-recognized.
Q. Is it peer-reviewed?
A. It is.
Q. And are its articles routinely relied upon in the field?
A. In the field and by me.
Q. And were you aware of this article at the time you drafted your report?
A. Yes.
Q. This article is dated November 4th, 2008?
A. It is.
Q. And your report was in May of 2009, correct?
A. Correct.
Q. And you were familiar with this article at the time that you drafted your report, correct?
A. Not only was I familiar with it, I had several discussions with one of the coauthors about it.
Q. Were you aware of this article last week when I asked you if you were aware of any articles that supported the

notion of the use of the paraphilia NOS (nonconsent) diagnosis?

A. Yes.

THE COURT: When you asked him last week?

MR. GRADY: At his deposition.

THE COURT: Oh....

A. Yes.

Q. Can you read for me -- I'll zoom in on it -- the abstract that describes the general nature of this article?

A. You want me to read the entire abstract?

Q. Absolutely, please.

A. Okay. "There is legitimate concern in the psychiatric community about the constitutionality of sexually violent predator (SVP) commitment statutes. Such constitutionality depends on the requirement that a sexual offender has a mental abnormality that may make him commit violent, predatory sex offenses, and reflects almost exclusively a concern for public safety with little regard for notions of clinical sensibility or diagnostic accuracy.

However, given that mental health experts' diagnostic opinions are, and will continue to be important, to be important to the triers of fact in regard to the application of the SVP statute, we describe a valid means of making a DSM-IV-TR paraphilia diagnosis.

We also provide a three-step approach for the judicious

application of the diagnoses in a context of SVP commitment evaluations that emphasizes the importance of not making a paraphilia diagnosis based solely on the sexual offenses themselves. Finally, we discuss the appropriate use of the paraphilia NOS diagnosis in SVP cases."

Q. And the author of this article, Michael B. First is the same Michael B. First that is a member of the DSM-IV Task Force, correct?

A. Correct.

Q. But in the context of this article, Dr. First specifically addresses the use of paraphilia NOS (nonconsent), does he not?

A. Paraphilia NOS, yes.

Q. He does not address paraphilia NOS (nonconsent) at all?

A. Yes, he does address the nonconsenting aspects of it.

Q. Okay.

A. But I think you're confusing some terms, that's why I'm -- you asked me specifically earlier in the deposition of paraphilia NOS/nonconsent, I want to be clear, and then you're asking me -- it says here using paraphilia NOS and so --

Q. So at the deposition you were answering -- well --

A. You're asking me two different questions. You're talking about the Doren term; you're using the Doren term, and this is not using the Doren term. This is using -- it's

highlighted, use of paraphilia NOS. Where do you see slash nonconsent?

Q. Let's just go down to the bottom of Page 451 of the article. The last paragraph, the first column: "In SVP commitment cases, the version of paraphilia NOS that has been most widely applied to offenders who have been convicted of raping an adult is often called paraphilia NOS (nonconsent)," did I read that correctly?

A. Right, and then they underline it completely.

Q. Well, let's come back to that. Now, Dr. First goes on to say, in the next highlighted section: "The idea that rape might be the focal point of a person's sexual urges and fantasies is not novel." He says that, correct?

A. Yes.

Q. And you would agree, the idea that rape might be the focal point of a person's sexual urges and fantasies is not novel?

A. I would agree with that.

Q. And, in fact, Dr. First goes onto say: "In a similar diagnostic construct, paraphilic rape, also known as paraphilic coercive disorder, was considered by the DSM-III advisory committee for possible inclusion in the DSM-III Revision as a new type of paraphilia," correct?

A. Right, I'm aware of that.

Q. I've read that correctly?

A. Yes.
Q. "It was considered by the advisory committee to be relatively uncommon among men who commit rape," correct?
A. Exactly.
Q. And "it was to be distinguished from sexual sadism," which may involve -- "which may also involve fantasies of rape"?
A. Right.
Q. "By virtue of the fact that in sexual sadism the focus of the sexual arousal is the humiliation and suffering of the victim"?
A. Right.
Q. "In paraphilic coercive disorder, in contrast to sexual sadism, it is specifically the coercive nature of the sex act that is the source of the sexual arousal," correct?
A. Correct.
Q. And Dr. First goes on to specifically mention Mr. Jim Healy. He says: "In the case of paraphilic coercive disorder included in the DSM-III-R casebook, the individual with the paraphilia fantasized about rape but was repulsed if he felt the woman was in any way suffering."
Have I read that correctly?
A. You have.
Q. "The committee ultimately decided to recommend against including this diagnosis in" DSM-IV" -- excuse me, "III-R

because of concerns raised that the category might be used by rapists to reduce criminal responsibility. Hence, the proposed category did not even appear in the August 1st, 1986, second draft of the DSM-III-R diagnostic criteria," correct?

A. Correct.

Q. That's what Dr. First writes in any event?

A. In the first edition, yes.

Q. Certainly, Dr. First is aware that paraphilic coercive disorder was rejected as a separate diagnosis, correct?

A. Yes.

Q. Dr. First goes on in the article looking at Page 452; would you like a copy by the way or is it easy to read along?

A. It's easy enough to read along; I have a copy in my bag. I can read it fine.

Q. "Conceptually," Dr. First goes on, "given the wide variety of stimuli known to be the focus of paraphilias, there is no reason to doubt the existence of a paraphilia in which the aberrant focus of sexual arousal is precisely the nonconsensual aspect of the interaction."

Have I read that correctly?

A. You have and I agree with it.

Q. "The problem, of course," and you'll probably agree with this: "The problem, of course, is that most rapists are not known to be driven by paraphilic fantasies and urges,

and there are inherent difficulties in differentiating those rapists who are driven to rape by such paraphilia, for most rapists commit rapes for other reasons."

Have I read that correctly?

A. Yes, that's exactly what I've been testifying to.

Q. So for clarity's purposes there is no doubt that the paraphilic NOS diagnosis may be applied, as Dr. First suggests, to individuals in which the aberrant focus of sexual arousal is precisely the nonconsensual aspect of the interaction?

A. Absolutely. If you can find them, sure.

Q. Okay. And, of course, the problem is finding them?

A. Exactly.

Q. Okay. But as a diagnosis, paraphilia NOS is correct where appropriately applied?

A. I would agree again, yes.

Q. Now, Dr. First goes on to note -- I'll have to slide it in; I think Ian broke it -- "The appropriateness of using the paraphilia NOS category as any basis for SVP commitment is hotly debated," correct?

A. Correct.

Q. "Some have argued that it should be used rather liberally for any case in which an individual has repeatedly engaged in sexual behavior with nonconsenting persons, even in the absence of reliable data about the person's sexual

fantasies," correct?
A. That's the Doren position.
Q. Well, in your view, correct?
A. It's in my view, that's true. That's correct.
Q. And on the opposite end are those who argue that there are no circumstances in which it would be appropriate to use this diagnosis because "it is contrary to the intent of the drafters of the DSM and the consensus of scholarly opinion regarding its appropriate use."
Have I read that correctly?
A. You have.
Q. Okay. And you would fall into neither of those two camps, right?
A. I would not. I would fall somewhere in the middle.
Q. Okay. Ultimately, Dr. First offers his opinion?
A. Which I think is somewhere in the middle, yes.
Q. Okay. Can you read it for me?
A. Oh ... "Our inclination is to come down somewhere in the middle on the appropriateness of using the paraphilia NOS category as the basis for the claim that the individual's sexual offenses are driven by a mental disorder. There are certainly some dangerous sexual offenders in our society whose offenses are clearly driven by a paraphilic sexual arousal pattern involving fantasies and urges to commit rape, and it may be appropriate to apply diagnosis of paraphilia

NOS to such individuals.

On the other hand, given the implications of a false positive diagnosis; that is, indefinite, potentially life-long civil commitment, and given all of the complexities involved in determining whether rape is motivated by a paraphilia as opposed to other causes as discussed herein, we recommend that a diagnosis of paraphilia NOS be used only with extreme caution for sexual offenders incarcerated for raping adults, and that the diagnostician stringently follow the three steps that we have presented.

In such cases, it is especially important to go beyond the facts of the sexual offenses themselves before asserting the presence of paraphilia."

Q. Thank you. Do you agree with that, Dr. Plaud?

A. I agree with that as thoroughly and as completely as I could agree with any statement relating to this.

Q. Excellent. Thank you. Now, in the quote you have read we have heard about three steps for making the diagnosis, correct?

A. Yes.

Q. The first step, according to the article, is to discern whether there's a paraphilic sexual interest at work, correct?

A. Correct.

Q. And, indeed, the article specifically cautions that one should not discern the presence of paraphilia merely from the fact of conviction, correct?

A. Correct.

Q. And Dr. First illustrates this by saying: "If the criminal sexual behavior itself were sufficient for making the diagnosis of paraphilia, there would be no need for input from mental health professionals," correct?

A. Right.

Q. You would agree with that?

A. I would.

Q. Now, I'll return to Page 445 of that article. There is a section entitled: Step 1, Establishing the Presence of Paraphilia," correct?

A. Yes.

Q. And the first thing we need to look for, Dr. First starts with the statement: "The core diagnostic construct that forms the basis of the paraphilia category is that the person becomes sexually aroused in response to stimuli considered to be abnormal," correct?

A. Yes.

Q. And certainly becoming or having the focus on -- or strike that.

If a person becomes sexually aroused in response to rape, that's abnormal, correct?

A. Yes, absolutely. If that's the function of the arousal, yes.

Q. Sure. Dr. First identifies potential sources of information that are possibly useful, correct? He goes on on Page 447; can you read that for us?

A. "Sources of information that are potentially useful, although never definitive in the attempt to determine the presence of paraphilia, include: the diagnostic interview, self-report questionnaire, and history of specific types of sexual behavior. The diagnostic interview should include questions about the individual's sexual thoughts, fantasies, urges, interests, and behavior specific to both paraphilic and nonparaphilic targets.

Self-report questionnaires, for example, Clark's Sexual History Questionnaire Revised, can also be useful in providing a comprehensive assessment of sexuality, and some such instruments include normative data for male sex offenders.

Although the information gleaned from interviews and questionnaires is potentially very useful, one must always be sceptical about the veracity of methods that rely on self-report because of the legal and social sanction s offenders may face as a result of acknowledging their paraphilic interests in past illegal acts."

Q. Do you agree with that?

A. Yes.
Q. Dr. First indicates that evaluators have to be skeptical of self-reports, correct?
A. Yes.
Q. And you would agree?
A. Yes.
Q. When you interviewed Mr. Graham, if he denied having deviant sexual arousal to rape, he didn't get up and leave and say: Oh, we're all done, correct?
A. True.
Q. An individual subject to potential civil commitment is unlikely to volunteer such deviant arousal, correct?
A. I will say that it has happened, but it is a rare phenomenon, yes.
Q. Certainly. Well, let's go on with Dr. First's description of how we can go about finding the paraphilia ... he goes on to say, perhaps you could read the next sentence?
A. "A history of sexual offenses thematically related to paraphilia; for example, arrests for indecent exposure in someone with a possible exhibitionistic paraphilia, or arrests for child molestation, someone with possibly pedophilia is certainly relevant as a potential indicator of an underlying paraphilic arousal pattern.

However, as emphasized in this article, the fact that the person has a history of sexual offenses cannot by itself

be considered sufficient evidence that the offenses were the product of paraphilic sexual fantasies and urges."

Q. And do you agree with that?

A. Completely.

Q. Excellent. So you would agree that essentially the thematic, the theme here, two convictions for rape, one conviction for assault with intent to rape, is relevant, correct?

A. It's relevant.

Q. But it is not the "be-all, end-all" certainly, and we cannot make a determination that that behavior is driven by paraphilia merely from the existence of those convictions, correct?

A. Merely from the existence, true.

Q. Now, because we know that individuals are unlikely to volunteer that they exhibit deviant sexual arousal, Dr. First suggests what with respect to the deviant behaviors?

A. "The evaluator must delve deeper and examine the specific details of the sexual offenses to establish that the behaviors are being driven by paraphilic urges."

Q. That's what Dr. First writes, correct?

A. Yes.

Q. And you would agree with that?

A. Yes.

Q. Now, I take it, Mr. Graham did not volunteer to you that he experienced deviant sexual arousal to raping women?
A. No, he did volunteer other issues relating to anger at the time, but not -- no, he did not divulge any paraphilic sexual interests.
Q. Okay, but you would agree that we can place little value upon that?
A. I wouldn't place the absence of that information as indicative of anything.
Q. So if the diagnosis in this case is going to be properly made, we're going to have to delve into the details of the offenses, correct?
A. Well, I mean, yes, we're going to have to. That may not be the end of the analysis, but, yes, that would certainly be part of it.
Q. Mr. Graham has denied it; the only remaining source of the potential information are the details of the offenses themselves, correct?
A. Correct.
Q. Now, you indicated in the course of your clinical interview you asked Mr. Graham about the 1974 incident, correct?
A. I did.
Q. And he denied committing the rape, correct?
A. Correct.

Q. Difficult to ask follow-up questions about his motivations concerning an event he denies, correct?
A. I would agree.
Q. Okay, and so you didn't really have a lot of follow-up questions in the 1974 --
A. Well, I asked him to explain in as much detail as he could his version of what happened. He denied the rape, but he did not deny having had a longer term sexual relationship with the victim beginning when they were teenagers, knowing the victim, interacting with the victim ... so to that extent, I got more information than just: No, I didn't do it.
Q. Okay. Do you credit those statements?
A. No. As I said earlier I got the information, and I summarized it in my report.
Q. Okay. But I'm going to recall back to when we were discussing Jim, you said: I'd want to know more about sexual sadism, correct?
A. Right.
Q. And you'd use the clinical interview to ask about particular details in order to develop information on sadism, correct?
A. Right.
Q. And that's the same type of investigation you'd want to do in this case, correct?

A. Correct.
Q. You'd want to ask specific questions of Mr. Graham of specific behaviors in order to sort of tease out some of the details, correct?
A. Sure.
Q. Some of his motivations, correct?
A. Sure.
THE COURT: With this in light, someone coming to your office for evaluation and treatment; here, we have an adversary proceeding that's designed to determine whether somebody's going to go to jail for a long time, if not forever.
THE WITNESS: Right.
THE COURT: Doesn't that make a difference?
THE WITNESS: It sure does.
Q. Well, you were hired by or you were selected by Mr. Graham's attorneys, correct?
A. Yes, I was selected, but that doesn't change the way I do my work.
Q. Okay. You'd ask the same questions, do the same clinical interview, investigate in the same way?
A. Well, but --
THE COURT: I'm not talking so much about what he does; if you were talking about my question --
MR. GRADY: I'm sorry, your Honor; I think I had

moved on from it but --

THE COURT: It's the --

MR. GRADY: -- the Court has the floor so....

THE COURT: No, no. What I'm hearing makes me want to point out what's on my mind; and, that is, that this is very different from an academic evaluation for purposes of treatment. Here, not only are the stakes different, you know, jail perhaps, but you have a relationship that's different; you have an adversarial relationship.

When somebody goes to the doctor, nobody's trying to punish them; they go to see if they can help them; here, there's been a predetermination made. I'm not saying that it's wrong. There's been a pre-determination made that there's a likelihood that this man ought to be retained and suffer, you know, perhaps a lifetime in jail. It's already been decided by somebody. I have to listen to everybody, and then decide whether that's the ultimate finding.

MR. GRADY: That's certainly correct, your Honor. I don't believe that my questions are directed towards impugning that thought in any way.

THE COURT: No, I don't think they were either. I guess I wanted to strike, you know, strike that note and get a response to see whether everybody thought I was on the right page, that's all.

MR. GRADY: I unquestionably agree that the Court

must make first a determination of whether this diagnosis even exists, and, second, the determination of whether it applies to Mr. Graham.

I believe that following questions will illustrate to the Court from the government's perspective why it is that it would feel that Dr. Plaud might not have investigated in the clinical interview as much as was possible.

In this particular case the government's expert was not allowed to interview Mr. Graham, and they could not answer these questions. If the concern is Mr. Graham has no obligation to provide information --

THE COURT: And not that it's gospel, but in the other two cases I've had we followed this same procedure.

MR. GRADY: Absolutely.

THE COURT: Okay.

Q. I'm just going to come back to the 1975 offense. Similar to the 1974 offense, Mr. Graham denied the event, correct?

A. Correct.

Q. And you asked -- you presented the official version which was fairly sparse?

A. Correct.

Q. Mr. Graham acknowledged that while he did not commit the rape, he plead guilty -- excuse me, did not commit the assault with intent to rape?

A. Correct.
Q. He plead guilty to that offense because he was advised by his attorney that if he went to trial and lost, he would go to jail for a very, very, very long time, correct?
A. That's what my recollection is, yes.
Q. Dr. Plaud, where in your report or your notes does it reflect that you asked Mr. Graham, even presuming he denies the event, what did they say you did?
A. Would you ask me that again, please?
Q. Sure. There's a paucity of facts in the official record, correct?
A. That's correct.
Q. And, certainly, we can infer from the fact that Mr. Graham acknowledges to you that he plead guilty to this offense, correct --
A. Right.
Q. -- that he was present when he plead guilty, correct?
A. True.
Q. Where in your report, where in your notes does it indicate that you asked Mr. Graham: What did they say that you did?
A. I did ask Mr. Graham that question, and I did report what he said back to me.
Q. Where is it reflected in your report that you asked Mr. Graham what did they say that you did?

A. Well, those are your words. I don't think I asked -- used those particular words. I asked him to tell me what he knew about this offense that he pleaded guilty to.

Q. Okay.

A. And as I reflected in my report, he said to me he didn't know exactly. He denied that he had even attempted to do anything. He didn't even know what the victim's name was, and then he proceeded to tell me why he pleaded guilty so he had -- he really to my -- to communicating with me during the interview, he didn't seem to know much about anything about the details of it.

Q. Dr. Plaud, you have been in this business for 22 years, correct?

A. Yes.

Q. And you have become familiar as a result with the operations of the criminal justice system of the United States, correct, to some degree?

A. I have.

Q. And you are aware that when an individual pleads guilty, there are facts to which he pleads guilty, correct?

A. Correct.

Q. And nowhere in your report does it say: well, Mr. Graham, even if you didn't do this rape, what were the facts that they said you did; it's not in there?

A. True.

Q. And there's nothing in your notes, there's nothing in your report, correct?

A. Correct.

Q. Let's look at the version of the 1987 offense that you put in your report. Now, I'm showing you a document. What is it?

A. That appears to be, it looks like, Page 6 of my report -- I'm sorry, Page 5.

Q. Can you read for us the facts of the event that you relate in your report concerning Mr. Graham's 1987 offense -- 1986 offense that he was convicted for -- or, excuse me, his 1987 offense. I apologize, go ahead.

A. "On May 24, 1987, Mr. Graham forced his way into the residence of a female. He choked her to unconsciousness, removed her clothing, and forced vaginal intercourse. On May 27th, 1987, he was arrested by the Prince George's County Maryland Police. He was charged with rape first degree. On March 4th, 1988 he was convicted in the Circuit Court of Maryland, Prince George's County, on the charge of rape. He received a sentence of 25 years.

On May 6, 2004, his parole was revoked, and there was a 1987 charge of rape. During the clinical interview Mr. Graham admitted to committing this governing sexual offense.

He stated that he was sitting at a picnic table in the

common area at the condominium development in which the victim was gardening. They had begun to talk and he did force himself on the victim.

Mr. Graham further stated that at the time of the commission of the governing offense he was angry and upset about his parole being violated (federal) and that he had returned to drinking alcohol and was intoxicated at the time. He expressed remorse for committing the governing sexual offense."

MR. GRADY: I apologize. May I have a moment, your Honor?

THE COURT: Uh-huh.

Q. Thank you for reading that, Dr. Plaud. Now, I'm just going to note that within the records you were provided was an appellant court decision from the Maryland Appeals Court, correct?

A. Correct, I believe I read it earlier.

Q. And I'm not going to have you read it because I think most of us could recite it at this point; I'm just going to show you that report begins on Page 512, correct, of the Bates-stamped materials, that decision of the appeals court?

A. Yes.

Q. Okay. Just a little minor issue, there was a certification of that record, correct?

A. Yes.

Q. Okay, and this is -- if we can look at it -- down on there Page 511, one page before, correct?
A. Correct.
Q. And this record, according to the certification, was generated on February 1st, 2008, correct?
A. Correct.
Q. It goes without saying that if you had prepared a report in March of 2007, you would not have had access to that document or that record, correct?
A. I did not have access to it.
Q. Well, no, no, no, no, if you had; your report is in March of 2009?
A. I'm sorry?
Q. Sure.
A. If I prepared my report?
Q. There's been some suggestion that an earlier physician ruled out certain things or -- strike that.
I'll just stand on the testimony; we'll strike what I just testified to.
Suffice it to say that this particular appeals court decision is a record that was generated in February of 2008, correct?
A. Right.
Q. Okay. Now, in the official version, which I will not have you read yet again, the victim was raped on multiple

occasions, correct?
A. Correct.
Q. The victim is choked on multiple occasions, correct?
A. Yes, twice according to that report.
Q. And in your report you do not reflect the victim was raped on multiple occasions, correct?
A. I did not report each occasion, that's correct.
Q. And you did not report that the victim was choked on multiple occasions, correct?
A. I referenced that she was choked, but you're correct; I didn't put on two occasions.
Q. But, nonetheless, we would, according to Dr. First's rules, want to delve into the specific facts of the offenses, correct?
A. Sure.
Q. Now, you actually noted that the choking was a particularly significant diagnostic fact, correct?
A. Potentially.
Q. Potentially, correct?
A. Yes.
Q. But in your report you don't even accurately report the number of times that it occurred, correct?
A. I was well aware that it was there. Look, that's fine because I --
Q. In your report it's not correct?

A. Well, it's correct that he engaged in it. I didn't put two times, on two occasions during that, that's correct.

Q. And you've indicated previously -- or strike that. You would agree that Mr. Graham's choking of the victim in this case is a possible indicator of both sadism and paraphilic sexual interest in nonconsenting sex?

A. More the former than the latter. I would definitely use it as an investigative -- more as a potential behavior going into a diagnosis of sexual sadism.

Again, this -- your use of the term nonconsent is your use of the term; there's no one way to conceive of that, whether it's choking or not.

Generally, I would say not with the choking unless it specifically had to do with sexual eroticizing around the nonconsensual aspect, but I've never experienced that before.

Q. It is something that is an indicator, albeit alone insufficient, that could lead to a diagnosis of both sadism and/or the paraphilia NOS regarding nonconsenting sex, correct?

A. I would concede the first, not the second, and I think it's coercive and not noncoercive.

Q. I'm just going to show you, do you recall being deposed in this matter?

A. Yes.

Q. On Page 86 -- 186 of your deposition I asked: "Are

there any aspects of his behavior, as reflected in these records, that are some evidence of a paraphilic interest in nonconsensual sex?"

Your answer: "Well, my answer would be in the instant or governing offense, we talked about the choking, and that's clearly something that might be evidence of that; or even more specifically, sexual sadism as a potential disorder"?

A. Right, sexual sadism. Correct, that's what I said.

Q. Clearly, that's something that might be evidence for that referring to a paraphilic interest in nonconsensual sex?

A. Well --

Q. This is what your testimony was?

A. Yes, I understand.

Q. I've read it correctly, have I not?

A. You have read it correctly but --

Q. Thank you. Now, again, bearing in mind that we have to undertake a detailed factual review in order to discern the presence of a paraphilic interest, and given that you use your clinical interviews to discern the motivations of people with respect to potential diagnoses such as sadism; both of those things are correct, are they not?

A. Well, not really.

Q. That's fine. You would agree that we need to delve into the details of the prior offenses in order to discern a paraphilic deviant arousal pattern, correct?

A. That's one source, yes. The details of the sexual offense history itself can provide important information, yes.

Q. And you've previously testified that you would use the clinical interview to attempt to tease out facts, correct, and you asked about an individual's motivations performing certain acts because the answers to those questions might assist you in making a diagnosis, correct?

A. Yes.

Q. There is no mention in your report, is there, that you asked Mr. Graham why he choked her?

A. Well, I did ask him --

Q. There is no mention --

A. -- why he committed the offense.

Q. -- in your report that you asked Mr. Graham why he choked the victim?

A. True.

Q. There is no mention in your notes --

A. True.

Q. -- correct? Let's just look at the statement we're all familiar with from having read the fact of that appeals court so many times.

"I've just got to put you out for awhile," that was a statement made by Mr. Graham according to the victim, correct?

A. Correct.
Q. And nowhere in your report, nowhere in your notes does it reflect that you asked Mr. Graham: Why did you make that statement, correct?
A. True.
Q. And nowhere does it reflect his answer?
A. True, because I didn't ask him.
Q. There is nothing in your report or your notes reflecting that you asked Mr. Graham why he choked the victim a second time, correct?
A. True.
Q. There's nothing about any answer he provided?
A. True.
Q. There is nothing in your report about a second rape, correct?
A. True.
Q. And there is nothing about your asking Mr. Graham why he committed a second rape, correct?
A. True.
Q. There is nothing in your report inquiring of Mr. Graham why he called a woman he had repeatedly raped, correct?
A. That's correct.
Q. And there's nothing in your notes to that effect?
A. That's right.
Q. Yet, you would agree with Dr. First's statement that we

have to delve into the facts of the prior offenses, correct, in order to find a paraphilic interest?

A. Well, I think we're mixing up a few things, but, yes, I would agree you have to delve into the facts. I was aware of all those issues going in. I have to choose in every case what I think is appropriate to ask and what gives me information, and if I included those things you asked of --

Q. I'm sorry, Dr. Plaud; there's no question in front of you.

MR. SINNIS: But there was a question and he cut him off.

THE COURT: Well, it's pretty hard to know. I think that his answer was going a little bit adrift, so we'll let whatever he answered stand, and then we'll go onto the next question....

Q. Now, I'm going to direct your attention to Page 10, and you mentioned this previously, that in your view Mr. Graham's past sexual offending behavior had to do with ongoing anger, power, and control issues exacerbated by his act of substance abuse at the time, correct?

A. Yes.

Q. And I've read that portion of your report correctly?

A. Yes.

Q. And that has been your testimony today, correct?

A. Yes.

Q. Now, you've previously agreed however that since Mr. Graham's denied committing the 1974 rape, you are unable to provide us with what his motivation was for the act he denies, correct?

A. True.

Q. And with respect to -- the same is true with respect to the 1975 assault with intent to rape that he denies, correct?

A. True.

Q. And you cannot indicate that his motivation for that crime was anger, power, or control issues exacerbated by substance abuse, correct?

A. That's true.

Q. And you have agreed that when the report speaks to this it is speaking solely to the 1987 offense that you discussed with Mr. Graham, correct?

A. Yes.

Q. And what, if you could tell me, was the source for that information that Mr. Graham was motivated by anger, was motivated by power issues, was motivated by ongoing substance abuse?

A. I had a detailed discussion with him about the commission of the governing offense, of which I reflected in my report, at least some of it; and Mr. Graham himself identified on the question of his motivation, asking him why he did what he did, he was talking -- he then started

talking about at the time, that would be back in 1987, the anger he was feeling, the fear that he had about violating his probation, and the anger surrounding that.

He had discussed his act of substance abuse earlier, and that type of response that you volunteered to me is certainly consistent with the vast majority, in the sense of motivating factors, for the rapists that I've dealt with over a number of years, and for which the professional community certainly considers to be motivating factors for rape; it matched up, and that would be my conclusion. There's no evidence of any paraphilic underpinnings.

Q. You can continue, but I asked you about what the source was. Are we getting a little away from that?

A. No. Okay.

Q. The source was Mr. Graham?

A. In part, as well as what his words matched with my own experiences dealing with rapists over the past 20-plus years.

Q. So the source of this is Mr. Graham's self-report, correct, the source of this information?

A. Partly, yes.

Q. And that matched up with what you sort of went in with as your assumptions about most rapists, correct?

A. The data on most rapists, which clearly are my assumptions, yes.

Q. Okay. Well, there's no reason to suspect going in

already, before we even get to your conclusions, that that same data applies to Mr. Graham, correct? You can't just start out saying Mr. Graham is the same as this data for most rapists, correct?

A. No, I wouldn't do that; but if, to be honest with you, if Ted Williams was batting for the Red Sox and I went to Fenway Park, I would be expecting I'd see a hit at the ball game.

Q. So with respect to Mr. Graham, you'd be expecting to see a dead body?

A. You know, that's just the issue: it's one of probabilities. Most rapists are not motivated by paraphilic urges.

Q. Great. Thank you. What I'm asking is: so your source for this information is Mr. Graham's self-report, correct, and your previous knowledge about what most rapists do, correct?

A. That is true in the absence of any supporting, specific data in the record that would be suggestive of a paraphilic sexual disorder.

Q. Thank you. Now, you've previously indicated that you agree with Dr. First's statement that we have to be somewhat suspicious of self-reports, correct?

A. Of course.

Q. Especially when -- well, in the context of this case, a

self-report that could be credited as against penal interests is: I'm interested in rape, correct?

A. True.

Q. Whereas, I'm just a normal rapist; I'm motivated by anger; I'm motivated by substance abuse; I'm motivated by power issues really isn't, correct? It doesn't hurt his civil commitment case, correct?

THE COURT: To do what?

Q. To acknowledge or to tell you that he was motivated by power and control issues or by anger, correct?

A. Sure. I guess I don't know what you mean.

Q. Well, let me step back for a moment. We would agree that one must be skeptical of self-reports, correct?

A. In these contexts I would agree in most cases, in most contexts, that if it's not against penile interests, you should be skeptical, yes.

Q. So you confirm -- well, strike that. You indicated, both in your report and in your deposition, that Mr. Graham reported to you that he committed this rape because he was angry about the possibility his parole could be revoked, correct?

A. That's what he said.

Q. And it was also -- he was also intoxicated at the time of the offense, correct?

A. Yes, he was.

Q. And those were both based on self-reports, correct?
A. True.
Q. So because you could not immediately credit the self-report, you looked for verification of this in the records, correct?
A. Yes.
Q. You had records from the Federal Parole Commission, correct?
A. Yes.
Q. And you had the records with respect to his 1987 offense, correct?
A. I did.
Q. And statements that he made about his intoxicated or non-intoxicated condition?
A. Right.
Q. When did the 1987 rape occur?
A. May 24, 1987.
Q. I'm just going to show you a piece of paper from Exhibit 17. You can take a look at it on the monitor or you can look at Exhibit 17 in the binder in front of you at Page 883. Do you see that down at the bottom of 883?
A. Well -- yes. Yes.
Q. Okay. Now, this is what?
A. A warrant, it appears to be.
Q. For a parole violation for whom?

A. Mr. Graham.
Q. Okay.
MR. SINNIS: Just could you move that ... thank you.
Q. When was the parole violation warrant issued?
A. May 5th, 1986.
Q. And Mr. Graham was angry about the possibility of his parole being revoked for an entire year prior to committing the rape, correct?
A. Yes.
Q. Where in the records, besides Mr. Graham's self-report, is there evidence that Mr. Graham was intoxicated at the time of the 1987 offense as you put in your report?
A. I don't recall any specific report indicating an independent --
Q. Do you recall any specific report that contradicts Mr. Graham's self-report concerning intoxication at the time of the 1987 rape offense?
A. I don't.
Q. You've previously testified, however, that when conflicted with the self-report, you would credit the official record, correct?
A. Sure.
Q. I'm going to show you a document from Exhibit 17, beginning on page Bates-stamped 792, and I'd ask you for a moment to -- can you tell me if you know what that is or if

you're able to zoom in on it?

A. Yes, it's a presentence investigation.

Q. And it's with respect to what offense?

A. I can't read that, I'm sorry ... the governing offense.

Q. The 1987 rape?

A. Yes.

Q. I'm going to direct your attention to the middle of Page 793. There is a section of the report entitled: "Statement of Defendant," correct?

A. Yes.

Q. And within that I have highlighted a portion, can you read that for the Court?

A. "He denied being under the influence of alcohol, drugs, or medication during the perpetration of the instant offense and at the time of his arrest."

Q. Okay. So when you indicate in your report that Mr. Graham is motivated by anger and intoxication to commit -- sorry.

When you indicated Mr. Graham has raped because of anger and intoxication, you were first only speaking of the 1987 rape, correct?

A. Yes.

Q. And you were speaking in direct contravention as to the intoxication issue to contemporaneous statements of Mr. Graham, correct?

A. Okay.
Q. Is that right?
A. Sure.
Q. And you were speaking about anger over a parole situation that had begun developing and had been resulted in the issuance of a warrant more than a full year before the rape, correct?
A. But that he was still out so....
Q. The situation that led to his being angry about his parole had begun more than a year prior, correct?
A. It appears to be from the documentation, but that doesn't rule out the fact that he could have been angry at the time or nervous, upset, just having a lot of lifestyle destabilization; that doesn't rule any of that out.
Q. In your report and in your deposition you testified he was angry because of the parole warrant; you didn't testify that he could have been angry about anything, did you?
A. That's not what I'm saying now.
Q. Now, you mentioned within your report when you're discussing paraphilia and nonconsent, what you previously alluded to as V codes, correct?
A. Yes.
Q. Now, I'm just going to try to do this quickly because I'm hoping perhaps we can actually finish your testimony today.

You would agree that the V code diagnosis exists for individuals who do not have a mental disorder, correct?

A. Correct. There are problems, behavioral areas that are attention of clinical focus.

Q. Okay, and the mere fact that there is a V code for sexual assault of an adult does not suggest that there is no diagnosis of paraphilia NOS predicated upon a deviant sexual arousal to coercive sex, correct?

A. That's true, if you can show that there is, absolutely; the same way there's a V code for abuse of a child and there's also pedophilia as a sexual disorder. There has to be the demonstration of the sexual arousal disorder component; that's the key issue.

Q. Let's speak very briefly about antisocial personality disorder. The prevalence of antisocial personality disorder in the general population is somewhere between 3 and 5%, correct?

A. Correct.

Q. Certainly abnormal in the general population?

A. Yes.

Q. Okay, and you would agree -- let me just direct your attention to Exhibit 20, Page 706, very quickly.

A. Yes.

Q. What are those?

A. Those are the diagnostic criteria: 301.7, antisocial

personality disorder.
Q. Excellent. We don't have to worry about any -- oh, by the way, is there a personality disorder NOS?
A. Yes.
Q. That is a valid diagnosis?
A. Yes.
Q. Okay. You would agree that Mr. Graham, let me just come back to this item, meets all of the criteria for an antisocial personality disorder, correct?
A. As I said earlier, by his record, he could, yes.
Q. Well, not by his record he could; by his record, he does meet the criteria?
A. Yes.
Q. But you do not diagnose him with antisocial personality disorder today, correct?
A. Correct.
Q. And you've mentioned the concept of burnout, correct?
A. Correct.
Q. And that is a well-recognized concept that, generally speaking, as individuals with antisocial personality disorder age, they can become, as someone has said: Older and wiser, correct?
A. True.
Q. And that that leads to less criminal offending?
A. It leads to less criminal offending. It leads to less

of the behaviors beyond criminal issues associated with an ability to comport one's behavior with social norms and acting in regard for the rights and safety of others.

Q. Okay. It leads to an amelioration of all of the items?

A. That's correct.

Q. That's a general rule?

A. I agree.

Q. It doesn't apply to all individuals who may be antisocial, correct?

A. It does not.

Q. And one of the categories where it has been shown empirically not to apply is to psychopaths, correct?

A. Well, psychopath, that's something a little different.

Q. Okay. Well, we'll get to that, but, certainly, there are individuals who do not experience burnout; is that correct?

A. Correct. No, I agree with you.

Q. In a typical case of burnout, you would see an individual become more remorseful about their prior criminal acts; you would agree?

A. You could, sure.

Q. You could see an individual acknowledge that they had done horrible things and they would indicate: But that was the old me; I'm very sorry for those things? There would be behaviors to show remorse, correct; that would be one

manifestation of --

A. True.

Q. -- burnout?

A. Yes.

Q. Mr. Graham, by contrast to that just one example I've given you, continues to deny that he committed a rape in 1974, correct?

A. Correct.

Q. And he continues to deny that he committed assault with intent to rape in 1975, correct?

A. Correct.

Q. So at least in this regard, Mr. Graham is inconsistent with the manifestations you were suggesting, correct?

A. To an extent.

Q. Now, it's not the only one?

A. Right.

Q. But one of the criteria is deceitfulness, correct?

A. Yes.

Q. And do you recall if I asked you whether you credited Mr. Graham's denial of committing the 1974 rape?

A. I do vaguely remember it, yes.

Q. And do you recall saying that you credited the official record?

A. I do.

Q. And as a result, I inquired, if Mr. Graham -- if the

official record is correct, if Mr. Graham committed the 1974 offense, he lied to your face in the interview, correct?

A. That would be the inescapable conclusion.

Q. And in fact --

MR. GOLD: Objection to lied in your face.

THE COURT: You know, it's just me here.

MR. GRADY: I'm sorry, your Honor. I'll withdraw the question.

Q. Mr. Graham lied in the interview?

A. If what you say is true, that would be the conclusion.

Q. And if he committed the 1975 assault with intent to rape, he denied it to you in the interview; he lied about that as well, correct?

A. Yes.

Q. And those are examples of ongoing, present deceitfulness, correct?

A. It would be.

Q. And if he indicated to you that he was intoxicated at the time of the 1987 rape and you credited the official record of the contemporaneous statements where he denies being intoxicated, he would be lying about that as well, correct?

A. That would be the implication.

Q. That would be an example of ongoing deceitfulness; one of the characteristics of antisocial personality disorder,

correct?
A. True.
Q. And if, in fact, Mr. Graham committed the 1974 rape, the 1975 assault with intent to rape, and continues to deny those offenses, he is showing no remorse, correct, for those offenses?
A. Yes.
Q. And the lack of remorse is an additional antisocial personality disorder characteristic, correct; and if that is true, if what I have said is true, he has an ongoing issue with that, correct?
A. If what you say is true....
Q. Any antisocial personality disorder, you would agree, can make it more likely that a person with paraphilia would act with paraphilic urges?
A. Well, it's a bit more complicated than just what you said, but it can, I believe, under certain circumstances. Although, I think there's more attribution going on to some discussion of that but --
Q. Well, the two can operate comorbidly as it's described, correct?
A. It's possible.
Q. In that, antisocial can contribute to the inability to control paraphilic urges; it's certainly possible?
A. If there are established paraphilic urges present, it's

possible.

Q. Okay. What is a comorbid condition?

A. A comorbid condition means more than one condition coexisting at the same time.

Q. Do you recall -- or strike that. I'll just finish here. One other --

MR. GOLD: Your Honor, if I might just interrupt, I just wanted to alert the Court to our scheduling issues with --

MR. GRADY: You know what, Judge ... I'm sorry, I tried; I don't know if I'm going to finish tonight.

THE COURT: You're going to finish at 4:30. What you do next week is something else.

MR. GRADY: Okay. Well, I'm apologizing for not finishing the entirety of Dr. Plaud's cross both to you and Dr. Plaud, I tried to --

THE COURT: Well, you do have redirect, don't you?

MR. GOLD: Well --

MR. GRADY: I still have more questions.

MR. GOLD: We would have to take Dr. Plaud out of order or I'd be willing, if the Court were interested, to forego redirect.

THE COURT: I don't care. You keep including me; I don't have a vote in what you do....

MR. GOLD: Well, just if the Court was inclined to

go over 4:30.

THE COURT: No, I'm not. The Court is going to leave here at 4:30 and my staff is tired; everybody else is tired. This poor court reporter's been whacking away with almost no recesses.

MR. GOLD: Okay.

MR. GRADY: I think she's had to type that fast 80 times ... should I continue questioning or should we just address the issue of when he's going to come back, your Honor?

THE COURT: Whatever you can do in the next 30 seconds, because that's what you have left on that point....

MR. GRADY: Excellent.

Q. Dr. Plaud, I'm going to show you an article -- or strike that. I'm going to show you a document, and tell me what it is?

A. Yes, it's another publication in the Journal of American Academy of Psychiatry and the Law.

Q. Okay. A published, peer-reviewed journal, correct?

A. It is.

Q. Well-respected?

A. Very.

Q. Okay, and the article of this -- excuse me, the author, Alan Francis, was the editor-in-chief of the DSM-IV, correct?

A. Correct.

Q. The book that we rely upon for finding diagnoses, correct?

A. Yes.

Q. Okay. And the other authors, tell us about them, if you would, very briefly?

A. They are psychologists who are experts in this area.

Q. Okay.

THE COURT: Okay. Monday, what is it, 10:00? Did Zita tell you?

THE CLERK: Yes, 10:00.

MR. GRADY: Your Honor, there is just one caveat: we will be starting with Dr. Mills and finishing Dr. Plaud.

THE COURT: Whatever you agree to....

MR. GOLD: We're agreed to it.

THE COURT: You present me with an agreed-upon agenda Monday, and we'll follow it.

MR. GRADY: We're agreed. Thank you, your Honor.

MR. GOLD: Thank you.

THE COURT: Thank you. Have a nice weekend.

THE CLERK: All rise....

(Whereupon, the proceedings concluded at 4:30 p.m.)

C E R T I F I C A T E

I, Helana E. Kline, a Registered Merit Reporter, Certified Realtime Reporter, and Federal Official Court Reporter of the United States District Court, do hereby certify that the foregoing transcript, from Page 1 to Page 195, constitutes, to the best of my skill and ability, a true and accurate transcription of my stenotype notes taken in the matter of the United States of America v. Wesley Graham.

/s/ Helana E. Kline September 17, 2009

Helana E. Kline, RMR, CRR

Federal Official Court Reporter